

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02507

2524

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 1, Film G194 3-21-56 et

1. PLACE OF DEATH- COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Lodge Forrest, Dist.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 12 Moreland Nursing Home		STREET ADDRESS (If rural, give location) 317 S. Chapel Street	
3. NAME OF DECEASED (Type or Print)	(First) Michalena (Lena)	(Middle) Anuszewski	(Last) (Anderson)
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept 26, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME John Lentz		14. MOTHER'S MAIDEN NAME Agnes Janowski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-1478	17. INFORMANT AND ADDRESS Joseph Anuszewski 317 S. Chapel Street

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause Hypostatic Pneumonia		24 hrs
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last Cerebral Hemorrhage		2 mos.
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

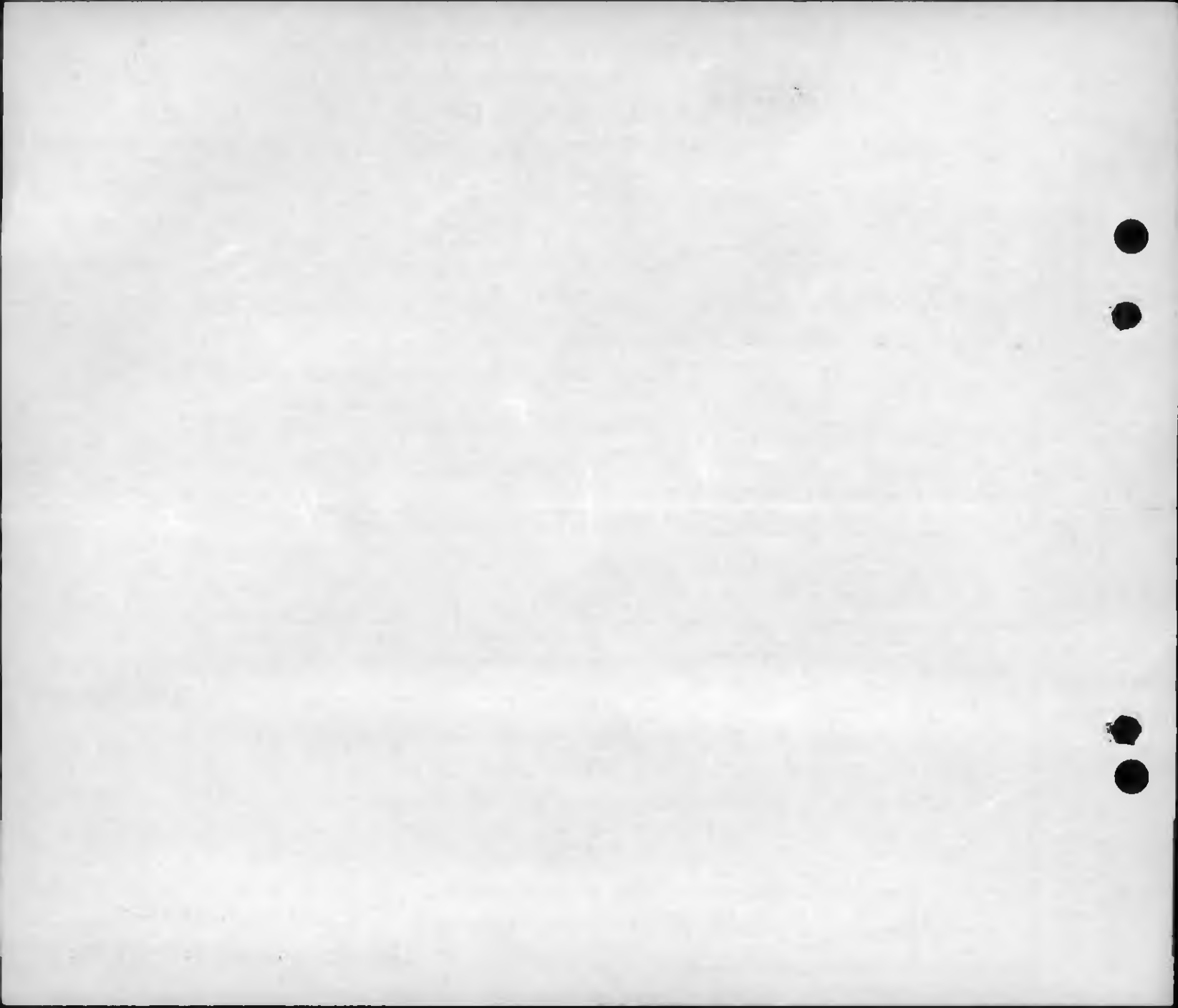
22. I hereby certify that I attended the deceased from Mar. 9, 1956, to Mar. 12, 1956, that I last saw the deceased alive on Mar. 12, 1956, and that death occurred at 6:10 P.M., from the causes and on the date stated above.

SIGNATURE <u>James T. Mean</u>	(Degree or title) M.D.	ADDRESS 500 2nd St. Balto 19 Md	DATE SIGNED 3/14/56
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF March 16, 1956	NAME OF CEMETERY OR CREMATORY Holy Rosary	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REG. 3-15-56	REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	24. FUNERAL DIRECTOR Lilly & Zeiler Inc., 403 S. Wolfe St.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2513

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 6905 5th. Ave.				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk TOWN STREET ADDRESS (If rural give location) 6905 5th. Ave.			
3. NAME OF DECEASED: (First) Joseph (Middle) Thomas (Last) Alex				4. DATE OF DEATH: March 16, 19 56			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Feb. 9, 1904	
9. AGE last birthday 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): welder		10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel		11. BIRTHPLACE (State or foreign country): Sparrows Point, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: George Alex		14. MOTHER'S MAIDEN NAME: Rose Baumgartner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) none	
16. SOCIAL SECURITY NO. yes		17. INFORMANT & ADDRESS: Clara Alex 6905 5th Ave. Dundak		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary Occlusion							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Jan. 1955, to 3/16, 1956, that I last saw the deceased alive on 3/15, 1956, and that death occurred at 10:20 M, from the causes and on the date stated above.							
SIGNATURE Joseph R. Lohr				ADDRESS M. D. 3508 Bank St.		DATE SIGNED 3/17/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 19, 1956		NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemt		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS John A. Moran 3000 E. Baltimore St			

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AC 3164-3

STAFF OF THE SECRETARY OF DEFENSE

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

2525 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>2 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		<u>0913.2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>6 Cedar Street</u>			
3. NAME OF DECEASED (Type or Print) <u>SAMUEL</u> (First) <u>ANDREWYWECH (ANDREWS)</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>March 26 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>September 13, 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pinsk, Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Andrewywech</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
(If Yes, give year or dates of service) <u>WW I</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) <u>LOBAR PNEUMONIA, RIGHT UPPER AND LEFT LOWER</u>							
ANTECEDENT CAUSE(S) (B) <u>XXXXX LOBES</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>1. CIRRHOSIS OF LIVER. 2. ARTERIOSCLEROTIC HEART DIS.</u>						UNKNOWN	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 24</u> , 19 <u>56</u> , to <u>March 26</u> , 19 <u>56</u> , and that death occurred at <u>6:30 A.</u> from the causes and on the date stated above.							
SIGNATURE <u>Donald D. Mark</u>		ADDRESS (Street, city, town, state) <u>DONALD D. MARK</u>		DATE SIGNED <u>3/26/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-29-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
24. REC'D BY REGISTRAR <u>March 29, 1956</u>		REGISTRAR'S SIGNATURE <u>Marion L. Larkins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Re Comptee</u>		ADDRESS <u>Le Comptee Funeral Home, Cambridge, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1956

Form with multiple horizontal lines for text entry, including fields for name, date, and cause of death.

BUREAU V. 2

MAR 29 1956

RECEIVED

2526

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLANDCITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE LENGTH OF STAY (in this place) 10 yearsTOWN CATONSVILLEHOSPITAL OR INSTITUTION OR STREET ADDRESS 14 SPRING GROVE ST. Hg.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY ? Prince GeorgesCITY (If outside corporate limits, write RURAL and give nearest town) CARMODY HILLSOR TOWN CARMODY HILLSSTREET ADDRESS (If rural give location) ?

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

HOWARD ARRINGTON

4. DATE (Month)

(Day)

(Year)

OF DEATH: 3 / 3 1956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MWMarried3/3/191145 yrs.MonthsDays

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

None—VIRGINIAby birth

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

WASHBURN ARRINGTONMINNIE BASE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

——Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

260x

IMMEDIATE CAUSE

(A)

Diabetic Coma

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B)

Uremia

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/6, 1945, to 3/3, 1956, that I last saw the deceased alive on 3/3, 1956, and that death occurred at 5⁵⁵ P M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

JRCowenM.D. Spring Grove Hosp.3/3/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

R. S. HALL - DEPT. OF HEALTH

ADDRESS

Burial3/6/56MonmouthPrince Wm. Co. Va.3/4/56T.E. HarryR. S. Hall - Dept. of HealthBy JRCowen

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 6 1956

RECEIVED

2519

CERTIFICATE OF DEATH

02510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4106 Leeds Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William P. Bach		4. DATE OF DEATH 3-14-56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1876
9. AGE (In years) 79 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired silversmith		10b. KIND OF BUSINESS OR INDUSTRY Steiff Co.	
11. BIRTHPLACE (State or foreign country) Howard Co., Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-07-8740	
17. INFORMANT Lawrence Bach, 4106 Leeds Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular (c) ?			INTERVAL BETWEEN ONSET AND DEATH 15 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 1955 to March 14, 1956 , that I last saw the deceased alive on March 14, 1956 , and that death occurred at 4 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl Pass, M.D.		ADDRESS (Street, city or town, state) 4001 Wilkens Ave Baltimore, Md.	
PHYSICIAN'S NAME (Type) T. EARL PASS, M.D.		DATE SIGNED 3-16-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-17-56	22c. NAME OF CEMETERY OR CREMATORY St. Paul's	22d. LOCATION (City, town, or county) (State) Arcadia, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR MAR 19 1956	
24b. REGISTRAR'S SIGNATURE Dr. Geo. S. M. Kupper			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
MAR 19 1956
BUREAU V. A.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02511

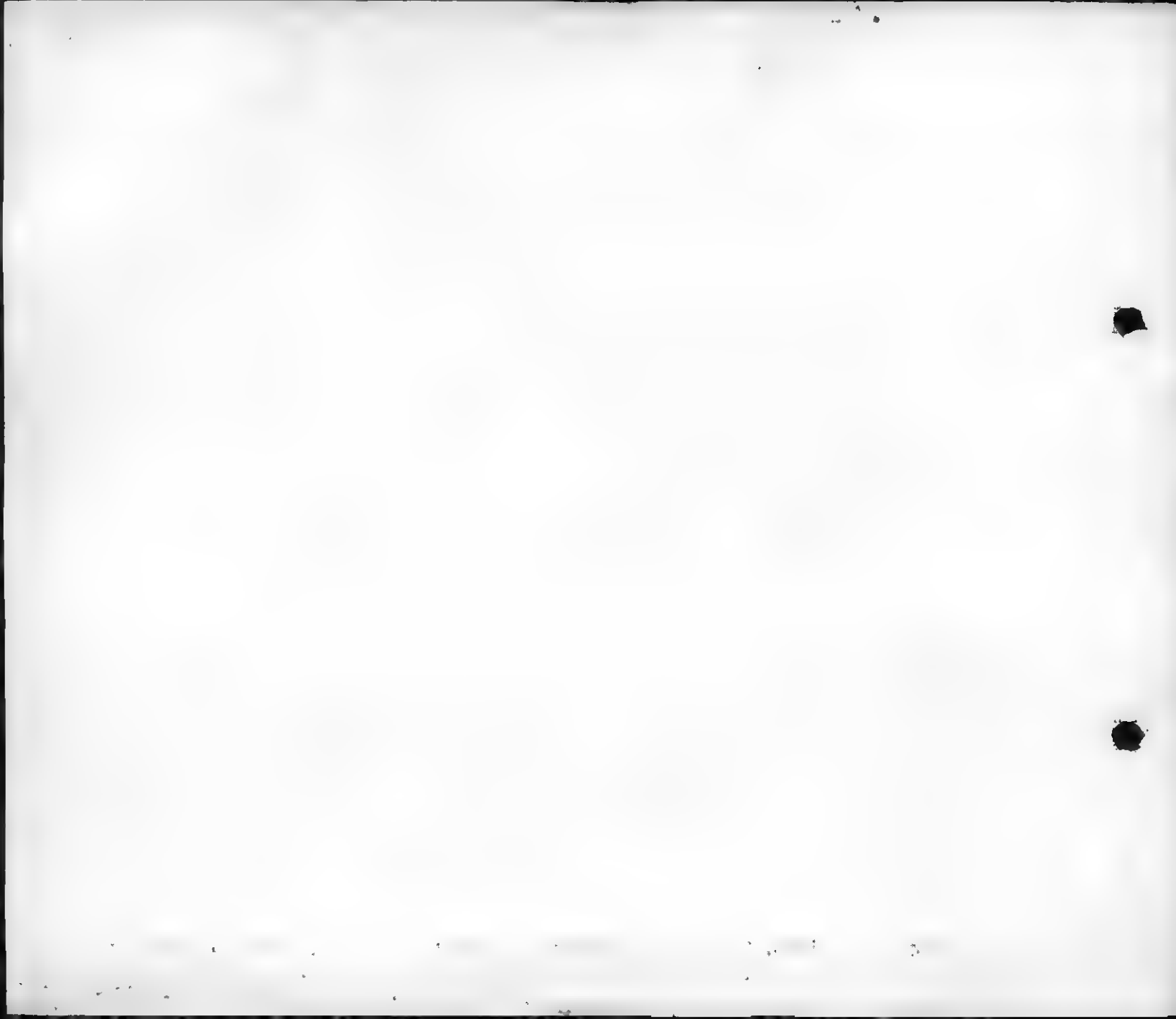
2527

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 2, Fil 243-21-6 et

1 PLACE OF DEATH:				2 USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY OR (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Baltimore 7th</u>		<u>2 mos.</u>		TOWN <u>Baltimore 29th</u>		<u>4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Robt Nursing Home, Essex St</u>				STREET ADDRESS <u>4219 Vermont Ave. NE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Thomas Bruce Baldwin</u>				<u>Mar. 8 1956</u>			
5. SEX. <u>Male</u>		6. COLOR OR RACE. <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>married</u>		8. DATE OF BIRTH: <u>Nov. 6, 1898</u>	
9. AGE last birthday: <u>57 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk retired Gps & Electric Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas Clinton Baldwin</u>				14. MOTHER'S MAIDEN NAME: <u>Ann McDonald</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>				16. SOCIAL SECURITY NO: <u>212-05-4197</u>		17. INFORMANT & ADDRESS: <u>Mrs. J. B. Baldwin 4219 Vermont Ave. Baltimore 29th</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>						<u>2 yrs</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8 Jan., 1956</u> , to <u>8 Mar., 1956</u> , that I last saw the deceased alive on <u>5 Mar., 1956</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul H. Royce</u>		ADDRESS <u>Pikesville 8th</u>		DATE SIGNED <u>8 Mar 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR. 10/56</u>		NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-1</u>		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>Harvey H. Witzke</u>		ADDRESS <u>4101 EDMONDSON AVE</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and the funeral director must sign the certificate. After the certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02512

2528

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8401 Harford Road #14		d. STREET ADDRESS 8401 Harford Road #14 <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr. Samuel Jennings Bateman		4. DATE OF DEATH March 19 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/31/1897
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD Md. PENN	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD Md. PENN		10b. KIND OF BUSINESS OR INDUSTRY BALTE. Md.	
11. BIRTHPLACE (State or foreign country) BALTE. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL BATEMAN		14. MOTHER'S MAIDEN NAME MARGARET O'LEARY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 213 20 6206	
17. INFORMANT Mrs. Ann M. Bateman		Address 8401 Harford Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS IMMEDIATELY CAUSED BY: (a) Coronary Thrombosis DUE TO (b) Arteriosclerotic Cardio Vascular DUE TO (c) Renal Disease & Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day 5-October 1953	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-Oct-1953 to 19-Mar-1956 , that I last saw the deceased alive on 19-Mar-1956 , and that death occurred at 1030 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas W Edmonds M.D.		ADDRESS (Street, city or town, state) 2746 The Alameda Balto -18-Md	
PHYSICIAN'S NAME (Type) Chas. W Edmonds M.D.		DATE SIGNED 19-Mar-1956	
22a. BURIAL-CREATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/22/56	
22c. NAME OF CEMETERY OR CREMATORY London PARK		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

U. A. 001

1951

7

Reg. Dist. No.

2529

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		d. STREET ADDRESS Joppa Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Joppa Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY E. BEALL				4. DATE OF DEATH Month March 15th, Year 1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 20, 1882	
9. AGE (In years last birthday) 74 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Francis				14. MOTHER'S MAIDEN NAME Emma V. Henry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT Mr. Dallas I. Beall, Joppa Rd., Fullerton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic COMA-UREMIC PERICARDITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF LEFT BREAST DUE TO (c) METASTASIS TO BRAIN, LYMPH NODES & LIVER						INTERVAL BETWEEN ONSET AND DEATH 4-6 DAYS (4-5 YRS)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Hour a. m. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from APRIL 1, 1955 to MAR 15, 1956 , that I last saw the deceased alive on MAR 15, 1956 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3009 EVERGREEN AVE BALTO MD DATE SIGNED 3/16/56							
ACTUAL SIGNATURE Donald W. Mintzer		PHYSICIAN'S NAME (Type) DONALD W. MINTZER					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/18/56		22c. NAME OF CEMETERY OR CREMATORY Camp Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Fullerton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louise Farnell				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR March 20, 1956	
						24b. REGISTRAR'S SIGNATURE Mrs. R. L. Ruffalo	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

VS A15 (4)
15M 9/55

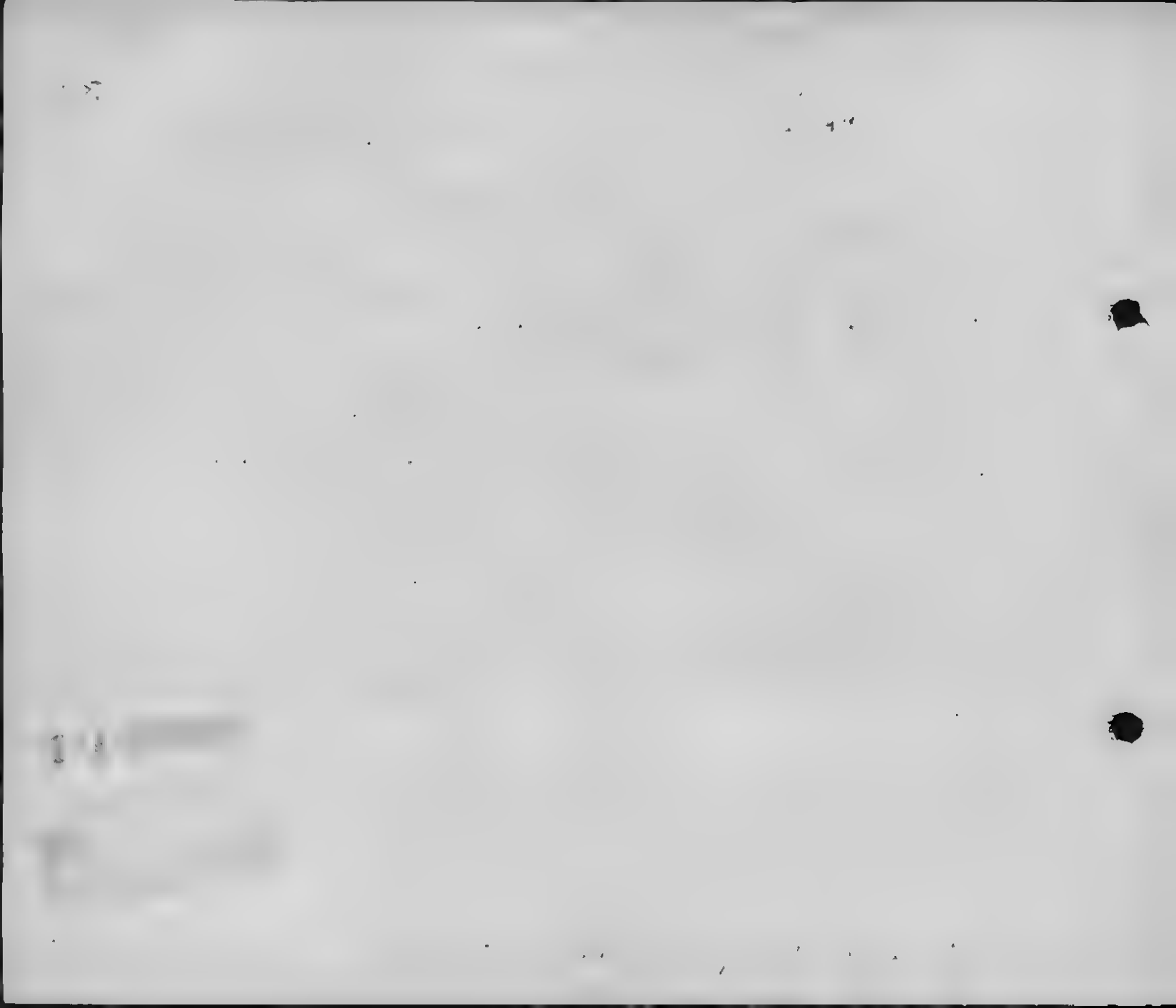
5. 2. 1900

56

100. 3.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2530 MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18				02514 Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Baltimore		MARYLAND	STATE Md.		COUNTY Carroll
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Reisterstown Rural		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Westminster		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westminster Road			STREET ADDRESS (if rural, give location) Westminster		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
(Type or Print) James	Henry	Beaver	March	11,	19 56
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR
M.	W.	Single	Dec. 25, 1907	48	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
Labor for Contractor			Maryland		USA
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Granville Beaver			Evelyn M. Reynull		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
yes W.W. II		219-01-2026	Joseph H. Beaver R.F.D. Westminster, Md		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Fractured Skull(base)					immediate
DUE TO					
Antecedent cause(s) (b) Compound Fracture Rt. Leg					immediate
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?	
none		none		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office, bldg., etc.)		21c. (City or town) (County) (State)	
		Westminster		Rd., Reisterstown, Balto., Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 3-11-56 11:30 P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
				Struck by automobile	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		M. D.			
D. H. Caples		3-12-56			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
		3-14-56	Reisterstown	Carroll Co. Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
3-12-56		Mary B. Eline		H. Bankard & Sons Westminster, Md.	



2531

CERTIFICATE OF DEATH

Reg. Dist. No. *32*

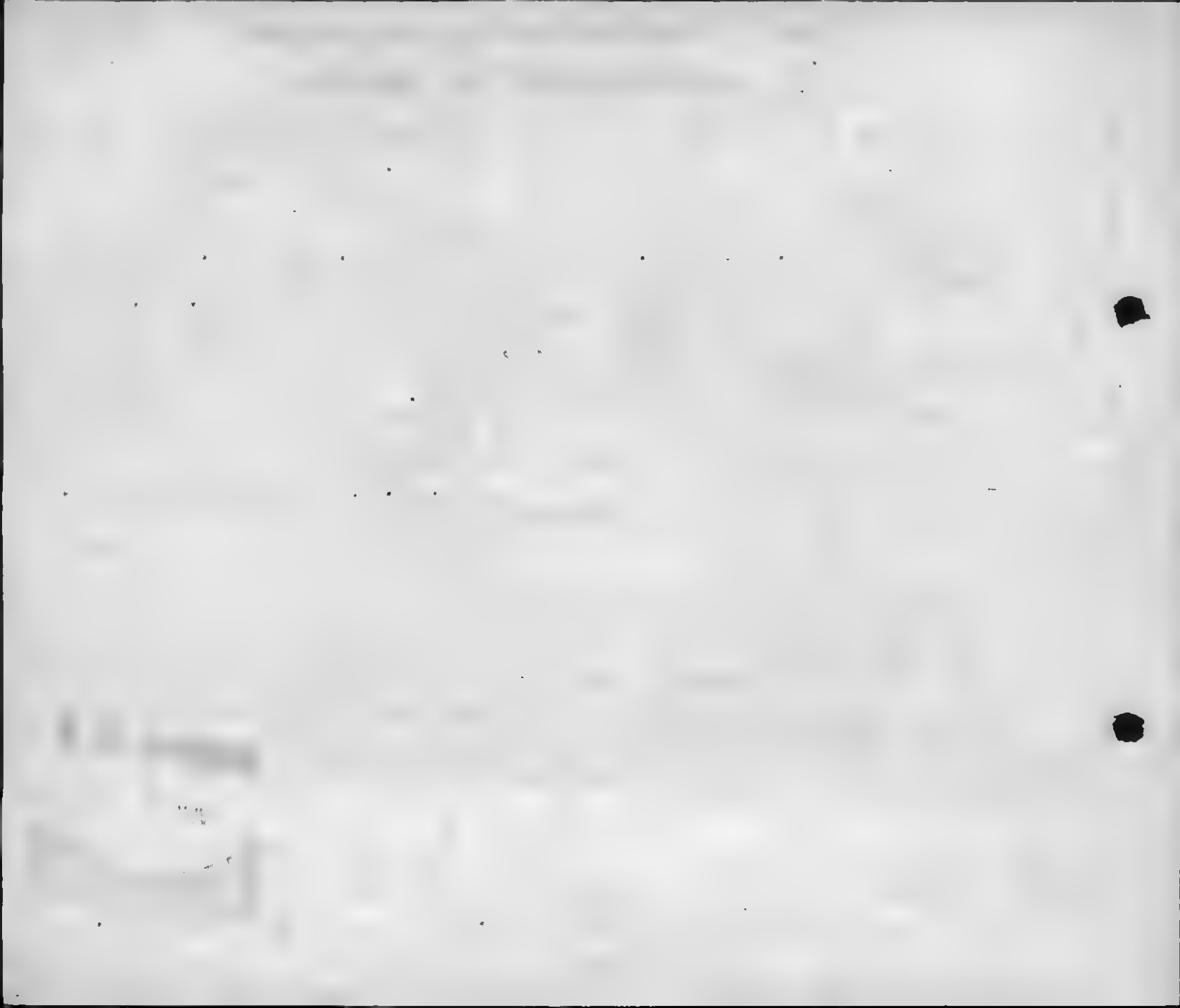
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1002 N. Rolling Rd.				STREET ADDRESS (If rural give location) 1002 N. Rolling Rd.			
3. NAME OF DECEASED (Type or Print)		(First) GEORGIE		(Middle) SWOPE		(Last) BENJAMIN	
4. DATE OF DEATH		(Month) Mar.		(Day) 31,		(Year) 19 56	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Aug. 7, 1862		9. AGE last birthday 93 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Swope				14. MOTHER'S MAIDEN NAME Susanna Boyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Wm. A. Milby-3614 Hillsdale Rd.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Myocarditis						Indefinite	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis						Indefinite	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pneumonia 1 month ago						1-	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 19 54 to Mar. 31, 19 56 , that I last saw the deceased alive on Mar. 31, 19 56 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.							
SIGNATURE Nathaniel M. Beck		DATE THEREOF 4/3/56		NAME OF CEMETERY OR CREMATORY Evergreen Cem.		LOCATION (City, town, or county) (State) Gettysburg, Penna.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR APR 3 1956		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons		ADDRESS Ba Hannon #18 7nd	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



2520

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

47

1. PLACE OF DEATH a. COUNTY <u>Balto</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Acklinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Acklinton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>709 Maiden Chace Lane</u>		d. STREET ADDRESS <u>709 Maiden Chace Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie M Biermann</u>		4. DATE OF DEATH Month Day Year <u>March 6 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4 1887</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home duties</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Hawker</u>	
14. MOTHER'S MAIDEN NAME <u>Ann + known</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>11-1-111111</u>		Address <u>709 Maiden Chace Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO (b) <u>Coronary vascular disease</u> DUE TO (c) <u>Coronary vascular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo L M Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo L M Kieffer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>March 6 1956</u>	
22a. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22b. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. M. Walker</u>		24a. REC'D BY REGISTRAR <u>Mar 7 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Geo L M Kieffer</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after describe the certificate, writing word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

S A 1-1

MARYLAND STATE DEPARTMENT OF HEALTH

02517

2411 N. Charles Street, Baltimore

2532

CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>LIT.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9907 HARFORD Rd</u>		STREET ADDRESS (If rural, give location) <u>9907 HARFORD Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Charles</u> (Middle) <u>W</u> (Last) <u>Billingsley</u>		4. DATE OF DEATH (Month) <u>MAR</u> (Day) <u>17</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE , MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>APRIL 5, 1884</u>
9. AGE last birthday <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Billingsley</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Honey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>216-10-7615</u>	
17. INFORMANT <u>LLwood Billingsley</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.5</u> Immediate cause (a) _____ Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		Interval Between ONSET AND DEATH <u>1 wk.</u>	
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR? <u>While at Work</u>	
22. I hereby certify that I attended the deceased from <u>Jan 1954</u> to <u>Mar 1956</u> , that I last saw the deceased alive on <u>Mar 10, 1956</u> , and that death occurred at <u>7:00 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. Frank L. Hirsch</u>		ADDRESS <u>709 E. Enoch F. Evans & Son</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>March 20, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>1400 Wood</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>	
DATE RECD BY LOCAL REG. <u>3/21/56</u>		24. FUNERAL DIRECTOR <u>Chas. F. Evans & Son</u>	
REGISTRAR'S SIGNATURE <u>A.M. Bacon</u>		ADDRESS <u>8802 Harford Rd</u>	

BUREAU V. S.

MAR 11 1962

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2533 CERTIFICATE OF DEATH

02518

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md.</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington 23, D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 23, D.C.</u> d. STREET ADDRESS <u>4627 Newell Lane, S. E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harvey Russell Bingham</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/28/49</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> Hours <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harvey Russell Bingham</u>		14. MOTHER'S MAIDEN NAME <u>Lois Elizabeth Glazier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>ROSEWOOD RECORDS</u>	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Aspiration Pneumonia (both sides)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spastic Quadriplegia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March 3, 19 55</u> , to <u>March 31, 19 56</u> , that I last saw the deceased alive on <u>March 31, 19 56</u> , and that death occurred at <u>10:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carlos E. Arraiza</u> M.D.		ADDRESS (Street, city or town, state) <u>2920 N. Calvert St., Baltimore 18, Md.</u> DATE SIGNED <u>1/2/56</u>	
PHYSICIAN'S NAME (Type) <u>Carlos E. Arraiza, M. D.</u>		<u>2920 N. Calvert St., Baltimore 18, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>April 5-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rock</u>	22d. LOCATION (City, town, or county) (State) <u>Leviestown Maryland Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J F Elmer Sons Rustertown</u>		ADDRESS <u>4-3-56</u>	
24a. REC'D BY REGISTRAR <u>4-3-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B Elmer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Certificate has been signed by the attending physician and completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

APR 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2534 CERTIFICATE OF DEATH

02519

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> 1.m.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hospital</u>				d. STREET ADDRESS <u>916 Bay Ridge Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Blades</u>				4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>56</u> 19			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-1874</u>	9. AGE (In years last birthday) <u>81</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records of Spring Grove Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensatory heart disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary abscess</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> Years _____ 3 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2.26</u> 19 <u>56</u> to <u>3.26</u> 19 <u>56</u> , that I last saw the deceased alive on <u>3-26</u> 19 <u>56</u> , and that death occurred at <u>8.30P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachler</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u>				DATE SIGNED <u>3-27-56</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachler</u>		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellevue Court</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyle + sons</u> ADDRESS <u>Annapolis, Md</u>				24a. REC'D BY REGISTRAR DATE <u>3 26-56</u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harvey</u>	

S A 100

2535 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
TOWN <u>Catonsville</u>		STREET ADDRESS (If rural give location) <u>4105 Liberty Heights Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shady Nook Nursing Home 1002 N. Rolling Rd.</u>			
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH <u>Mar. 8, 1956</u>	
5. SEX: 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): 8. DATE OF BIRTH:		9. AGE last birthday: 10. AGE UNDER 1 YEAR: 11. AGE UNDER 24 HRS.	
female white		62 yrs	
Housewife		W. Va.	
13. FATHER'S NAME: <u>Timothy O'Flaherty</u>		14. MOTHER'S MAIDEN NAME: <u>Bridget Quinlan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mr. George McManus, Jr-10 Light St.</u>	
16. SOCIAL SECURITY NO. <u>218-28-3193</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE		<u>Carcinoma of uterus</u>	
(B) ANTECEDENT CAUSE (S)		<u>Broncho-pneumonia</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>11/10/54</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of uterus</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1955</u> , to <u>3/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>56</u> , and that death occurred at <u>320A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>3/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/10/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 9 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	



2536

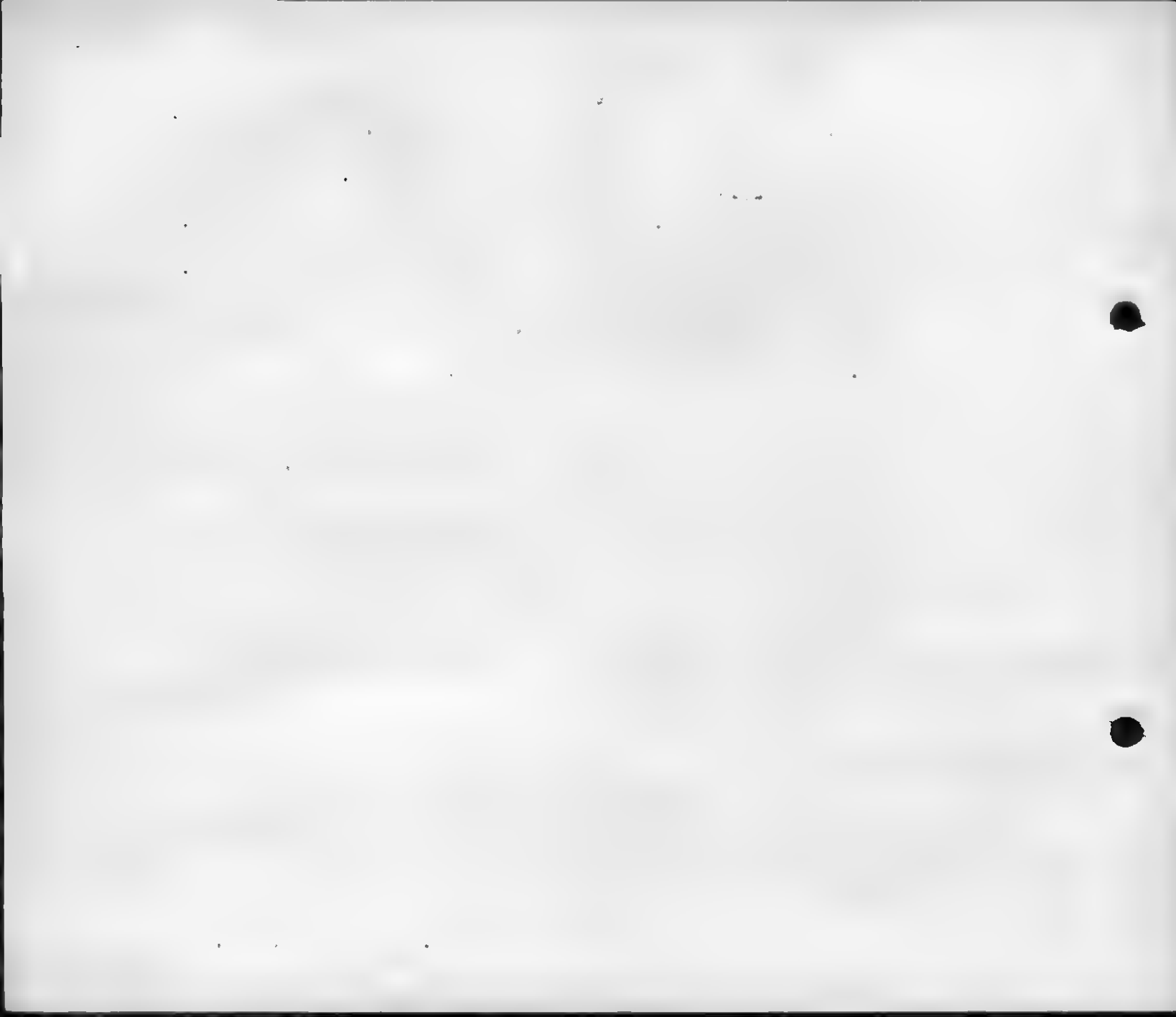
CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Balto.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Fusting Ave.		STREET ADDRESS (If rural give location) 1218 E. North Ave.	
3. NAME OF DECEASED: (First) MARY (Middle) ELIZABETH (Last) BOTELER		4. DATE (Month) (Day) (Year) OF DEATH: Mar. 5, 1956	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Sept. 20, 1889
9. AGE last birthday 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd. Post Office	11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: John McHugh	
14. MOTHER'S MAIDEN NAME: Catherine Agnes Coffay		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) --	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Miss Elizabeth G. McHugh-1218 E. North Av	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE Arteriosclerotic Ht Disease			1 year
(B) ANTECEDENT CAUSE (S) Diabetes Mellitus			10 years
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9 am , 19 55 , to 3 p , 19 56 , that I last saw the deceased alive on 3/3 , 19 56 , and that death occurred at 7a M, from the causes and on the date stated above.			
SIGNATURE Sol Smith		DATE SIGNED Mar 17 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/7/56	
NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		LOCATION (City, town, or county) (State) Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR 3/5/56		REGISTRAR'S SIGNATURE Dr. McHugh	
24. FUNERAL DIRECTOR Wm. J. Tucker & Sons - Balto 17 Md		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



2537 . CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore 19.</u> MARYLAND		STATE <u>MD</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sparrows Pt.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>in</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Todd ave.</u>		LENGTH OF STAY (in this place) <u>35 yrs.</u>		STREET ADDRESS <u># 1.</u>		(If rural, give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Phillips Henry BOWER.</u>				<u>March 14 19 56.</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>Feb. 10. 1880</u>	
9. AGE last birthday: <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>merchant marine</u>		11. BIRTHPLACE (State or foreign country): <u>Floyd. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME: <u>William Bower</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen Mary Bower</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY No.: <u>217-01-2887A</u>		17. INFORMANT & ADDRESS: <u>Clayton Bower (address as in #1)</u>		18. MEDICAL CERTIFICATION			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

162X
Immediate cause (a) Primary adenocarcinoma lung 6 mo.
DUE TO
Antecedent cause(s) (b) _____
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (c) _____

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from Sept 7, 19 55 to Mar 14, 19 56 that I last saw the deceased alive on Mar 13, 19 56 and that death occurred at 4:30 A m., from the causes and on the date stated above.

SIGNATURE <u>Louis N. Pollin, M.D.</u>		(DEGREE OR TITLE)		ADDRESS <u>6908 North P+ Rd Balto 14 Md</u>		DATE SIGNED <u>3/14/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>Mar 16 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Belair Memorial</u>		LOCATION (City, town, or county) (State) <u>Belair Md</u>	
DATE REC'D BY LOCAL REG- <u>15-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>William Funeral Home</u>		ADDRESS <u>2112 Sandath</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2538

02523

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 35

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore		STATE	Michigan	COUNTY Wayne
CITY (If outside corporate limits, write RURAL OR and give nearest town)			CITY (If outside corporate limits write RURAL and give nearest town)		
* TOWN Reisterstown			TOWN Detroit		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
Hanover Rd.			13129 Menbota Street		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
(Type or Print)	Karl H. Broker		March 18 19 56		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR
Male	White	Divorced	Sept. 21, 1888	67 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		
Insurance broker			Rome, N.Y.		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
Rome, N.Y.			U.S.		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Frank Broker			Barbara Ceinch		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):			16. SOCIAL SECURITY No.:		
No					
17. INFORMANT & ADDRESS:			1721 Seymour Ave. Utica, 3 N.Y.		
Mrs. Wilson D. Feistal					

18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary Occlusion					10 min.
DUE TO					
Antecedent cause(s) (b) Diabetes					1 wk.?
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?	
none		none		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY. none		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY. none M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? none	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
L. R. Cooper		M. D.		3-19-56	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		Mar. 21, 1956		Rome Cemetery	
24. FUNERAL DIRECTOR		ADDRESS		J. F. Eline & Sons, Reisterstown, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			
2-18-56					

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3

11

2539

CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 16 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5215 Old Frederick Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
3. NAME OF DECEASED (Type or print) CHARLES - RONALD BROWN		4. DATE OF DEATH Month MAR Day 28 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 16, 1891
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Harrisburg Pa		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William L. Brown		14. MOTHER'S MARDEN NAME Sarah Ann Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. none	
17. INFORMANT Anna E. Brown		Address 5215 Old Frederick Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 440X DUE TO Advanced hypertensive + arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) cardio vascular - renal disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 or 3 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6 Jan, 1951 to 28 Mar, 1956 that I last saw the deceased alive on 28 Mar, 1956 , and that death occurred at 3:10 P M from the causes and on the date stated above			
ACTUAL SIGNATURE Emil H Henning Jr M.D.		ADDRESS (Street, city or town, state) 601 Winans Way DATE SIGNED 29 Mar 56	
PHYSICIAN'S NAME (Type) EMIL H HENNING JR		601 WINANS WAY	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Mar 31/56	22c. NAME OF CEMETERY OR CREMATORY Lakewood	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE John F. Gensel ADDRESS 5311 Edmondson Ave		24a. REC'D BY REGISTRAR 1508 DATE 1508 24b. REGISTRAR'S SIGNATURE C. E. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 4

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Bethlehem Steel Co. Dispensary</u>				2. USUAL RESIDENCE (Where deceased lived If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Co. Dispensary</u>				d. STREET ADDRESS <u>1001 K St. Sparrow Pt.</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle _____ Last <u>BROWN</u>				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>June 6, 1896</u>		9. AGE (In years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR Months _____ Days _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mouldman Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Cumberland Co. Va.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Washington Brown</u>					
14. MOTHER'S MAIDEN NAME <u>Fannie Randolph</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. _____				17. INFORMANT <u>Marylou Williams Farmville Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardia-Vascular Disease with</u> DUE TO <u>auricular fibrillation.</u> (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>NONE</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>NONE</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B Davis</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>M. B. Davis</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>March 13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Farmville Va.</u>			
22d. LOCATION (City, town, or county) _____ (State) _____							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Robert A. Whitely</u>		ADDRESS <u>1129 N. Chesapeake</u>		24a. REC'D BY REGISTRAR DATE _____			
24b. REGISTRAR'S SIGNATURE _____							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



2521 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Halethorpe</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Halethorpe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2024 Northeast Ave.</u>		STREET ADDRESS (If rural give location) <u>2024 Northeast Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<u>James M. Bryde</u>		<u>Mar. 22, 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH:
<u>Male</u>	<u>Colored</u>	<u>Widower</u>	<u>May 26, 1874</u>
9. AGE last birthday		10. AGE last birthday	
<u>81</u> yrs		<u>81</u> yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Porter</u>		<u>Hotel (ret.)</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Unknown</u>		<u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>213-10-2127</u>	
17. MEDICAL CERTIFICATION		18. INFORMANT'S ADDRESS	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>Mrs. Mary Glasgow</u>	
IMMEDIATE CAUSE		<u>2024 Northeast Ave. Halethorpe, Md.</u>	
(A) <u>Mitral Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE (S)		<u>4 mo. 18 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Hypertensive Arterio-sclerotic</u>	
		(C) <u>Cardio-Renal Disease</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>II-6</u> , 19 <u>55</u> to <u>3-22</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3-22</u> , 19 <u>56</u> , and that death occurred at <u>3.00 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>C. J. Malone</u>		DATE SIGNED <u>57</u> ADDRESS <u>Winters Land</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>3/26/1956</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Mt. Auburn</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>MAN 26 1956</u>		<u>Holland Funeral Home</u>	
		<u>1631 Druid Hill Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11

EDWARD A. S.

1917
JUL 20 1917

2541

CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Baltimore MARYLAND			STATE Maryland COUNTY Charles		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head, Md.		
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRING GROVE STATE HOSP.			STREET ADDRESS (If rural give location) Indian Head, Maryland		
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH:		
(First) Florence (Middle) M (Last) BUCK			(Month) March (Day) 4 (Year) 19 56		
5. SEX. female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Nov. 12, 1898		9. AGE last birthday: 57 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: Oliver Wanner			14. MOTHER'S MAIDEN NAME: unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): unknown (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.: unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) Cerebrovascular accident					1 week
ANTECEDENT CAUSE (B) Hypertensive cardiovascular disease					Years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov 5, 1956 , to March 4, 1956 , that I last saw the deceased alive on March 4, 1956 , and that death occurred at 9:20 PM , from the causes and on the date stated above.					
SIGNATURE JR. Brown		M. D. Spring Grove Hospital		DATE SIGNED 3/4/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF 3-7-56		NAME OF CEMETERY OR CREMATORY MT. RAINIER	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR		ADDRESS	
DATE REC'D BY LOCAL REGISTRAR 3-7-56		REGISTRAR'S SIGNATURE J.E. Harris		ADDRESS 1111 N. ...	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1700000

6-5-1

2542 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Towson</i>	<i>Cryd</i>	TOWN <i>Towson</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1844 Yakona Rd</i>		STREET ADDRESS (If rural give location) <i>1844 Yakona Rd.</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>Decatur H. BURNETTE</i>		DATE (Month) (Day) (Year) <i>3-11-56</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>male</i>	<i>white</i>	<i>married</i>	<i>8-17-1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>farm manager</i>		<i>farm</i>	<i>Bristol, Tenn.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Decatur Burnette</i>		<i>Sarah N. Miller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>no</i>		<i>none</i>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<i>Mrs. B. Burnette, 1844 Yakona Rd, Towson 4, Md</i>		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>	
		ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized arterio-sclerosis</i>	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec 29, 1952</i> to <i>Mar 10, 1956</i> , that I last saw the deceased alive on <i>Dec 29, 1952</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Lee K Fargo</i>		DATE SIGNED <i>3-11-56</i>	
ADDRESS (Street, city, town, state) <i>M.D. 8155 Lock Road, Towson 4, Md</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>3-14-56</i>	<i>Edwards Cemetery</i>	<i>Bristol, Tenn.</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	
<i>REC</i>	<i>Metel Gray</i>	<i>Howard H. Hubbard 4107 Wilkens Ave.</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

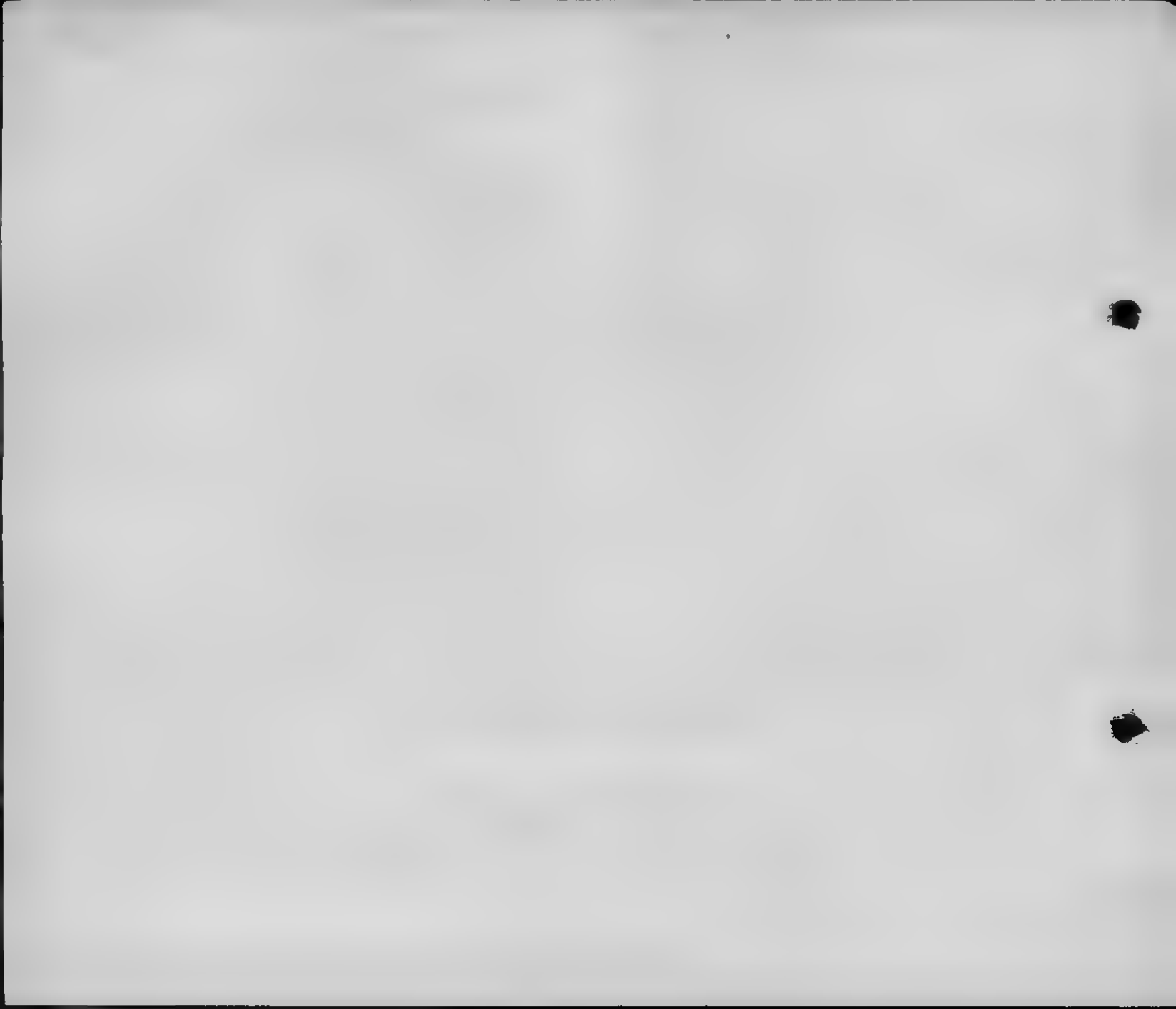
U. S. A. 1900

CHAS. H. K. 1900

2543

02529
Reg. Dist.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 1

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balti.</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Balti.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
X TOWN <i>Roundabout</i>	<i>8 yrs</i>	TOWN <i>Roundabout, Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Traver Rd.</i>		STREET ADDRESS (If rural, give location) <i>Traver Rd.</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>DOROTHY</i>	(Middle)	(Last) <i>BUTLER</i>	(Month) <i>3</i> (Day) <i>12</i> (Year) <i>1956</i>
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>		8. DATE OF BIRTH: <i>15, 1908</i>	
9. AGE last birthday: <i>47</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>	
11. BIRTHPLACE (State or foreign country): <i>Balti., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John Sczypanski</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Bernacki</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY No.: <i>218-34-0384</i>	
17. INFORMANT & ADDRESS: <i>Mary Catherine Butler Roundabout</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
4. Immediate cause (a)..... <i>Coronary Occlusion</i>			<i>1/2 hr.</i>
DUE TO			
Antecedent cause(s) (b).....			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>			
19a. DATE OF OPERATION: <i>None</i>		19b. MAJOR FINDING OF OPERATION: <i>None</i>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <i>None</i>	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>None</i> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>None</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>R.D. Caples</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>3-12-56</i>	
M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL, (Specify): <i>Burial</i>		DATE THEREOF <i>3/6/56</i>	
NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		LOCATION (City, town, or county) (State) <i>Balti. Md.</i>	
DATE REC'D BY LOCAL REG. <i>1</i>		REGISTRAR'S SIGNATURE <i>John Stansbury</i>	
24. FUNERAL DIRECTOR <i>John Stansbury</i>		<i>6411 Windsor Mill Rd.</i>	



2544

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTOWN BALTO 19th. 2 weeks</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>309 WESTSHIRE, RD</u>				d. STREET ADDRESS <u>SANDYVILLE, FINNBSBURG, MD.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>NATIE</u> Last <u>CAPLE</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1878</u>	9. AGE (In years last birthday) yrs <u>77</u>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>GEORGE W. ZEPP</u>			
14. MOTHER'S MAIDEN NAME <u>MARY GEMISON</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>William Scheide 309 Westshire Rd. Baltimore 19 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONIA</u> DUE TO (b) <u>CEREBRAL HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>POSS. CEREBRAL METASTASIS - CA BREAST</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>4 "</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>55</u> , to <u>MARCH 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MARCH 2</u> , 19 <u>56</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. W. Scheide</u>				ADDRESS (Street, city or town, state) <u>3921 Edmondson Ave. Balt. Md.</u>			
DATE SIGNED <u>3/4/56</u>				PHYSICIAN'S NAME (Type) <u>L. W. SCHEIDE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 7, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sandycrest Cemetery, Rural, Westminster, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Jones, Jr. Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>T. E. Harry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03654	
Medical Examiner										Reg. Dist. No. 40	
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE					b. COUNTY	
Baltimore					MARYLAND					Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Franklinville					35 yrs.,					Franklinville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Alice B. Carroll					March 30 1956						
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
female		white				Jan. 19, 1870		86		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Practical Nurse				Self Employed				Harford Co., Maryland		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
James Carroll					Anna E. Galloway						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address				
no					none		Clifton M. Dowling, Bel Air, Maryland.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Secondary Anemia</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Evening</u> <u>undet.</u> <u>undet.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>examined</u> 19 <u>after death</u> , 19 <u>after death</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>4:30 p. M.</u> from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>John C. Hyle</u>					M.D. <u>Deputy Medical Examiner</u> DATE <u>4-2-56</u>						
PHYSICIAN'S NAME (Type) <u>J.C. Hyle</u>					7527 Bel Air Rd., Balto., 6 Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)			
Burial			Apr. 3, 1956		Franklin Presbyterian			Franklinville, Balto., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs & Son</u>					ADDRESS Abingdon Md.		24a. REC'D BY REGISTRAR DATE <u>4-3-56</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. ...</u>		

BUREAU V. S.

APR 19 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2546 CERTIFICATE OF DEATH

02532
Reg. Dist. No. 33

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco			c. LENGTH OF STAY IN 1b 13 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hanover Road				d. STREET ADDRESS Hanover Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) William D. Cartzendafner				4. DATE OF DEATH March 23 19 56			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Sept. 3, 1892	
9 AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hunter Wilson Distillery Operar				10b. KIND OF BUSINESS OR INDUSTRY Mabyland		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Joshua Cartzendafner				14. MOTHER'S MAIDEN NAME Martha Ogle			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-6015		17. INFORMANT Mrs. Lola D. Cartzendafner, Upperco, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. Disease DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH 3 4 1/2 hrs. 10 yrs. </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1948, to March 23, 1956, that I last saw the deceased alive on March 22, 1956, and that death occurred at 2:00 AM, from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> <div> ACTUAL SIGNATURE Martin E. Strobel M.D. 48 Main St., Reisterstown, Md. </div> <div> DATE SIGNED 3/23/56 </div> </div>							
PHYSICIAN'S NAME (Type) Martin E. Strobel 48 Main Street, Reisterstown Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 25, 1956		22c. NAME OF CEMETERY OR CREMATORY Pipe Creek		22d. LOCATION (City, town, or county) (State) Carroll County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons				ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 3-23-56	
24b. REGISTRAR'S SIGNATURE Mary B. Eline							

22

W. H. H. H.

1881

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital. The attending physician and cemetery must be filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and cemetery, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

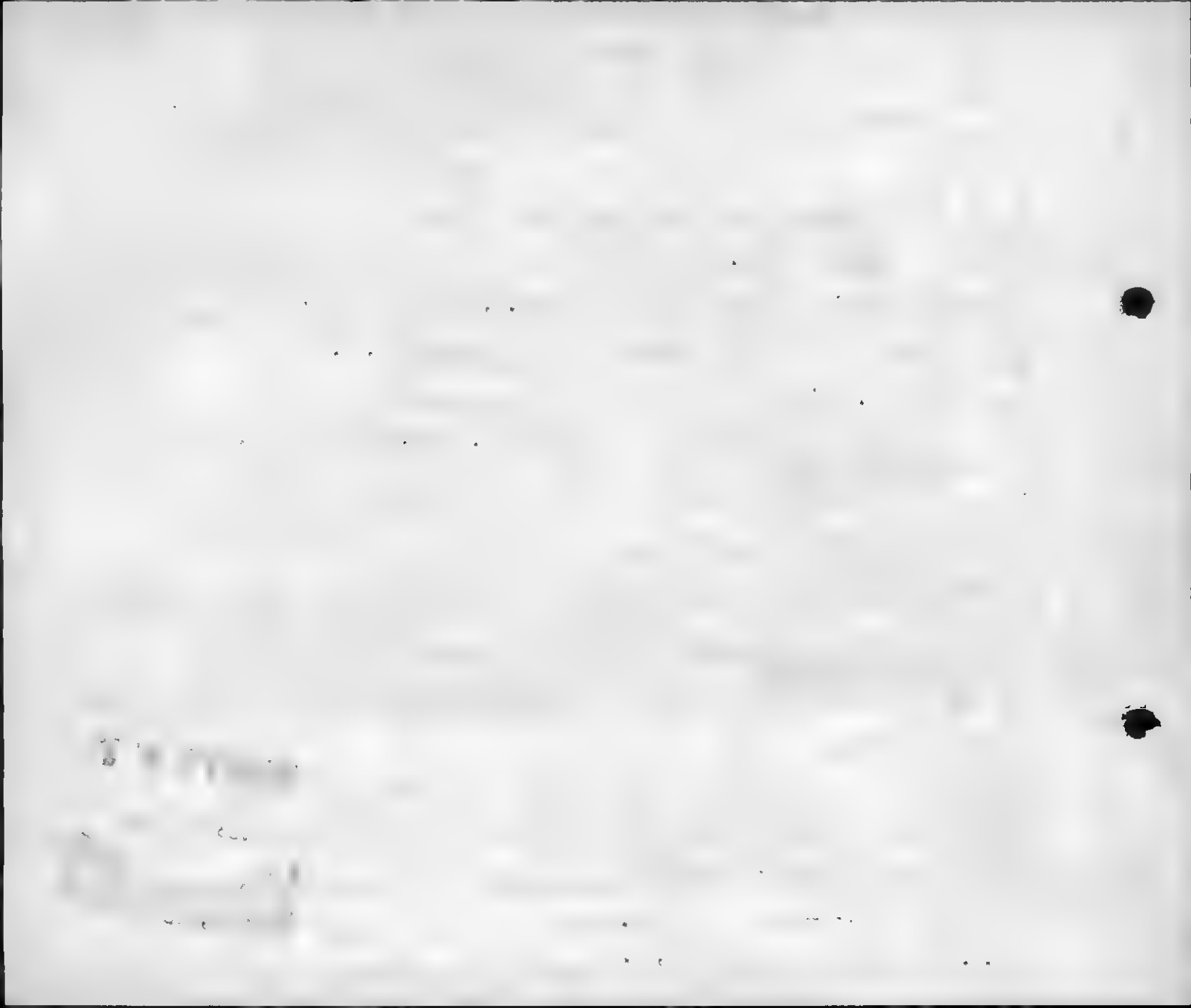
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2547 CERTIFICATE OF DEATH

02533

Reg. Dist. No. 36

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grays				c. LENGTH OF STAY IN 1b Grays			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION River Road				d. STREET ADDRESS River Road			
3. NAME OF DECEASED (Type or print) First LULA Middle A. Last CAVEY				4. DATE OF DEATH Month March Day 29 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1882		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Gainesville, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John H. Ellis				14. MOTHER'S MAIDEN NAME Annie Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address George C. Cavey, Ellicott City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-7 , 19 48 to 3/21 , 19 56 , that I last saw the deceased alive on 3/21 , 19 56 , and that death occurred at 11:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Burgtorf, M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 3/30/56			
PHYSICIAN'S NAME (Type) George E. Burgtorf, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-56		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR DATE 3/31/56		24b. REGISTRAR'S SIGNATURE V.E. Harry	



2548

CERTIFICATE OF DEATH

02534

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 10 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3601 Fait Avenue			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle PETER Last CELMER				4. DATE OF DEATH Month MARCH Day 17 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 18, 1929		9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER'S HELPER		10b. KIND OF BUSINESS OR INDUSTRY STANDARD OIL CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JESS W. CELMER				14. MOTHER'S MAIDEN NAME HELEN DEKOWSKI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) YES PL 28		16. SOCIAL SECURITY NO. 214-26-9250		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO SUBACUTE BACTERIAL ENDOCARDITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 3 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 7, 1956 to MARCH 17, 1956 , and that death occurred at 11:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 3-18-56 ACTUAL SIGNATURE William M. Lavette M.D. PHYSICIAN'S NAME (Type) William M. Lavette, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR 20 '56		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS CEM, BALTIMORE COUNTY, MARYLAND		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler		ADDRESS 901 S. Conkling St. Baltimore 24, Md.		24. REC'D BY REGISTRAR March 20 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Lister	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 10 1968
U.S. DEPT. OF JUSTICE

2549 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> 28				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hood Convalescent Home</u>				d. STREET ADDRESS <u>3412 Old York Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Bell</u> Last <u>Christie</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21, 1877</u>		9. AGE (In years last birthday) yrs. <u>78</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James Christie</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Clay Ware</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Balto., 29, Md.</u> <u>Mrs. G. Russell Thomas, niece, 4204 Leeds Av.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>4/22/56</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe Coronary Insufficiency</u> DUE TO (c) <u>Marked Atherosclerotic C-V-D</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>53</u> , to <u>3/11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/11</u> , 19 <u>56</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Victor F. King</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>715 Federal Rd #28 3/11/56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Victor F. King</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Russell Thomas, 4204 Leeds Avenue, Balto. 29, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3/11/56</u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

1961

LIBRARY

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02536
 2550 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>None</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Box 355A Route 10.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>Todds Farm Sp. St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Oliver A. Clatterbuck</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>3-6-1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>Aug. 5-1899</u>
9. AGE last birthday <u>56</u> yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Todds Farm</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Oliver Clatterbuck</u>	
14. MOTHER'S MAIDEN NAME: <u>Matilda Melles</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Effie Clatterbuck (Wife) Above</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Massive hemoptysis</u>			<u>30 min.</u>
ANTECEDENT CAUSE (B) <u>Far advanced Pulmonary Tuberculosis</u>			<u>4 years at least</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 15, 1955</u> , to <u>March 6, 1956</u> that I last saw the deceased alive on <u>Feb. 15, 1956</u> , and that death occurred at <u>9⁰⁵ A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>David A. Cueno</u>		DATE SIGNED <u>3/6/56</u>	
ADDRESS <u>Spanaway Point, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-9-56</u>	<u>Lock Lawn Em.</u>	<u>Eastern Bord. Camp</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3/6/56</u>	<u>H. H. Hedrick</u>	<u>✓</u>	<u>John B. Connelley Essex</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2551 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02537

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore <div style="text-align: center;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Timothy Lane		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle COMET Last COATES		4. DATE OF DEATH Month March Day 21 Year 1956	
5. SEX Mal.	6. COLOR OF RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1874
9. AGE (In years, last 5 the) 81		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman-transportation		10b. KIND OF BUSINESS OR INDUSTRY G&E Co	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wm. A. Coates		14. MOTHER'S MAIDEN NAME Mary E. Forsyth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Wm. A. Coates		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Lillie E. Coates		Address St. Timothy Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardio vascular disease (c) Cardio vascular disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. S.M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S.M. Kieffer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		March 21, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/24/56	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville Md
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner		ADDRESS 9 Lewis - Balto 17, Md.	
24a. REC'D BY REGISTRAR March 23, 1956		24b. REGISTRAR'S SIGNATURE T. E. Harrys	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

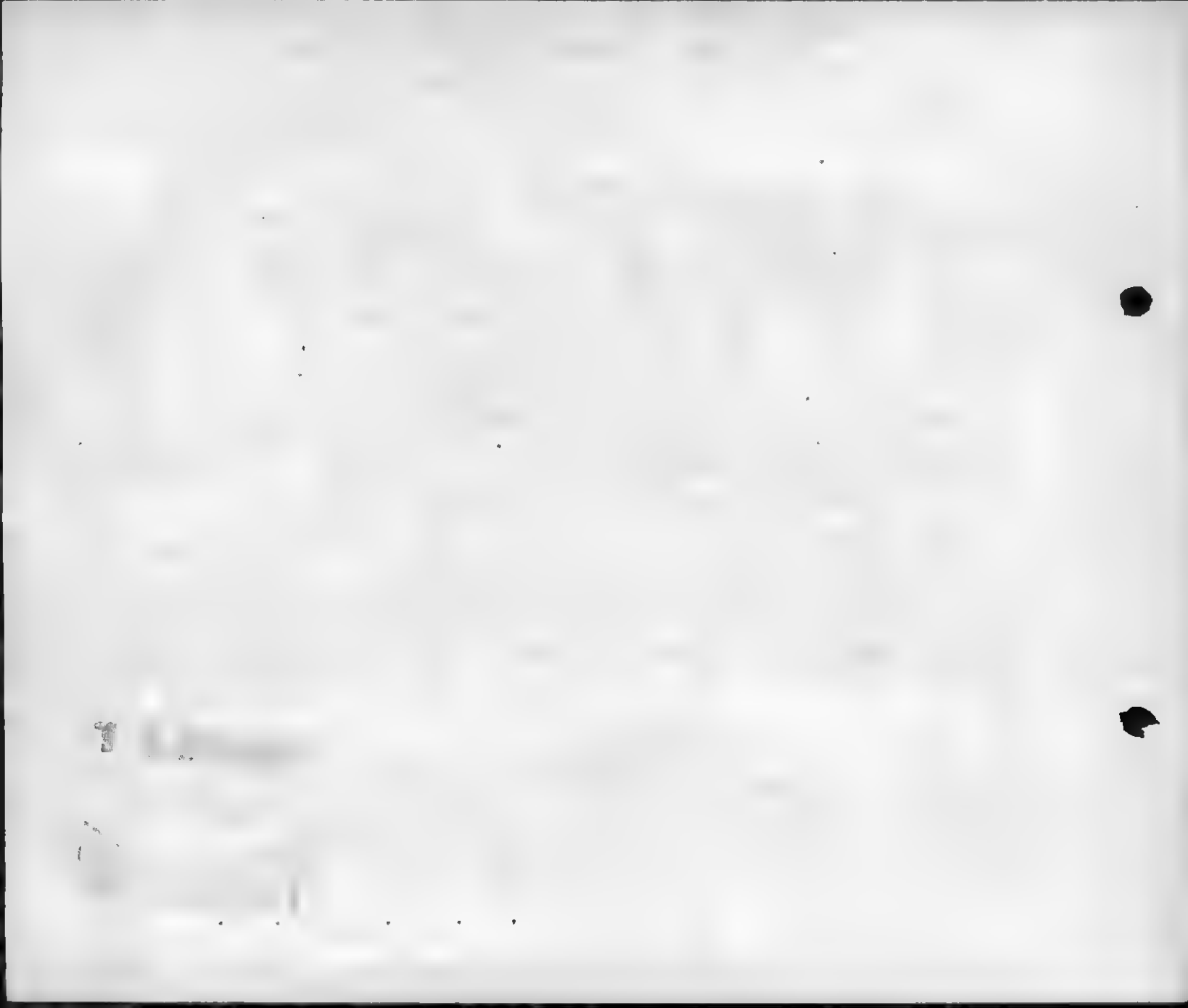
3.2.1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If the certificate is not executed within 24 hours after death, it should be executed as soon as possible. If the certificate is not executed within 24 hours after death, it should be executed as soon as possible. If the certificate is not executed within 24 hours after death, it should be executed as soon as possible.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02538		
2552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 38		
Item 7 FilmG194 3-4-56												
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Co.					c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 186 Dumbarton Road					d. STREET ADDRESS 186 Dumbarton Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last DOROTHY IRENE COMEAUX					4. DATE OF DEATH Month Day Year March 14 19 56							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1917		9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker				10b. KIND OF BUSINESS OR INDUSTRY Food Stores		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Harry W. Beck					14. MOTHER'S MAIDEN NAME Bess Bachtell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-10-3109		17. INFORMANT Address Mr. M.J.Comeaux-186 Dumbarton Rd.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Uremia due to chronic nephritis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO										INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE Russell S. Fisher, M.D.					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 3/14/56		
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 3/17/56		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk. Cem. Balto. Co.			22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE WIEDEFELD & SON						ADDRESS GREENMOUNT AVE & 22ND			24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

MAR 19 1956



02539

MARYLAND

STATE DEPARTMENT OF HEALTH

2553

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls</u>	
TOWN <u>College Manor</u>		STREET ADDRESS (If rural, give location) <u>Chestnut Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <u>GEORGE W</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>29</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>7-26-1867</u>	
9. AGE last birthday <u>88</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Lynn, Mass.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William P. Conway</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Upper Falls, Md.</u>		18. CITIZEN OF WHAT COUNTRY?	
19. DATE OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)...

Cardiac failure due to cor pulmonale
Emphysema, chronic bronchitis, bronchiectasis

Antecedent cause(s)

(b)...

Senility

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)...

Interochanteric fracture - L. femur

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

fall occurred in his room 4:00 a.m. 3/27/56

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify)
SUICIDE
HOMICIDEPLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1950 to March 1956, that I last saw the deceased alive on March 28, 1956, and that death occurred at 9:10 a.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

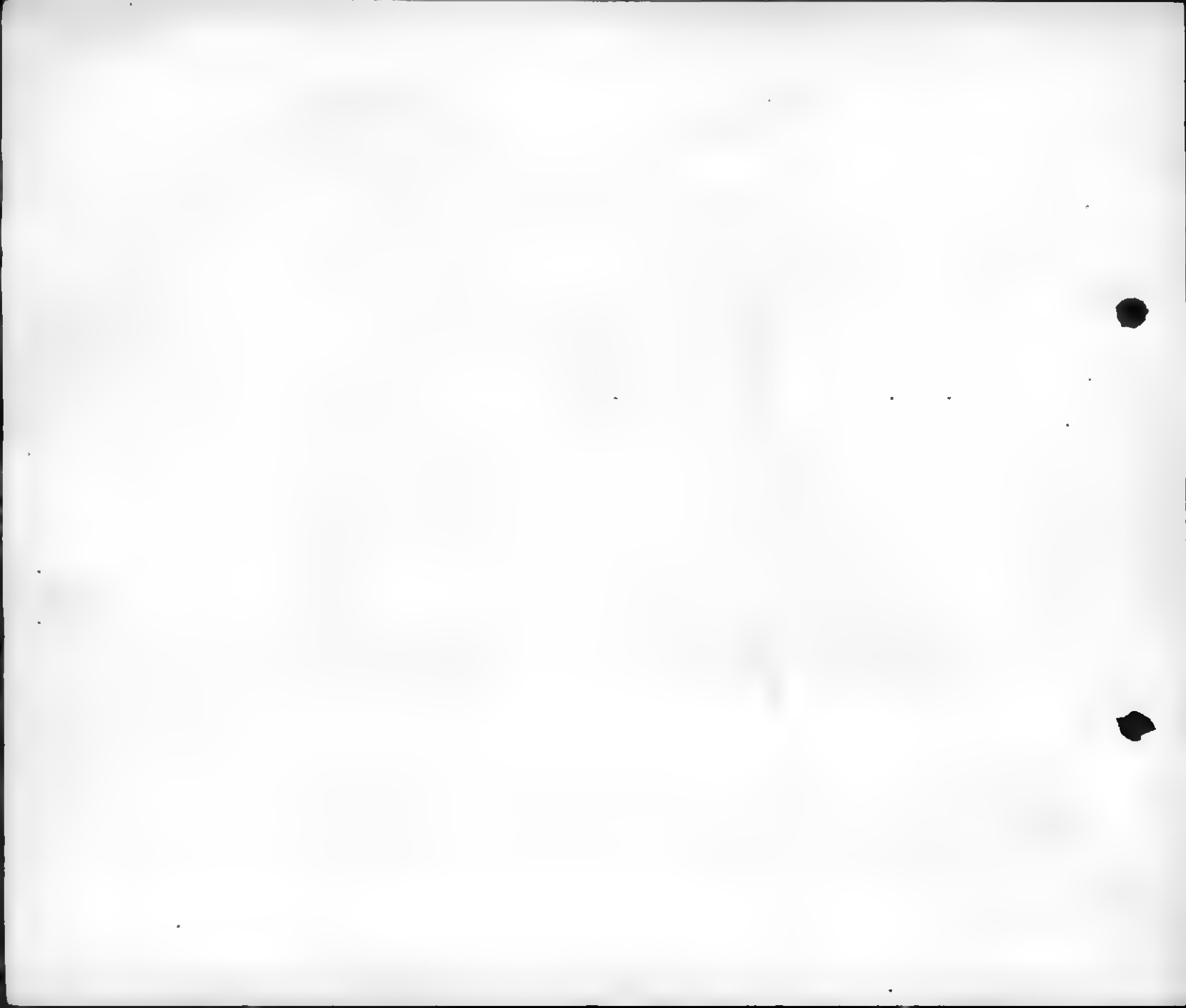
ADDRESS

Ok'd. by:

Rollin C. Hudson, M.D.Wm. J. Adams & Sons - Balto 17Md.

MARGIN RESERVED FOR BINDING

Dr. Tillman has talked to both Dr. Fisher and Dr. Hudson regarding this case.



02540

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2554

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH COUNTY <u>ALTO-G. Md</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>LATONVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>LATONVILLE - BALTIMORE COUNTY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5939 JOHNNY LAKE Rd</u>		STREET ADDRESS (If rural, give location) <u>5939 JOHNNY LAKE Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Thomas</u> (First) <u>A</u> (Middle) <u>COOPER</u> (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>19</u> (Year) <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4-17-1877</u>
9. AGE last birthday <u>78</u> yrs.		10. AGE last birthday If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKERY BUSINESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BAKER</u>	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>COOPER</u>		14. MOTHER'S MAIDEN NAME <u> </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>196-01-3008</u>	
17. INFORMANT AND ADDRESS <u>MRS SUE GREENGLASS - 5939 JOHNNY LAKE Rd</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE		INJURY				
HOMICIDE						
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-10-1956, to 4-19-1956, that I last saw the deceased alive on Mar 14, 1956, and that death occurred at a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>3-22-56</u>	<u>St. John's Episcopal Church</u>	<u>BALTIMORE</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
		ADDRESS		

THOMAS J. KENNY INC

1600 Hollins St

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2555 CERTIFICATE OF DEATH

02541
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcoast Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Minnie Middle B. Last Crossmore				4. DATE OF DEATH Month March Day 20 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1870		9. AGE (In years last birthday) 85 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.	
13. FATHER'S NAME Joshua Hammond				17. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Frank R. Hammond-Franklinville Rd. Upper Falls	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensation 42000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Pneumonia DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 6 days 7 days 15 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 1950 to March 20, 1956 that I last saw the deceased alive on March 20, 1956 , and that death occurred at 4:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles F. C'Donnell M.D. 2501 York Rd. Towson, Md. 42nd 3/21/56							
ACTUAL SIGNATURE Charles F. C'Donnell				PHYSICIAN'S NAME (Type) Charles F. C'Donnell M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 23, 1956		22c. NAME OF CEMETERY OR CREMATORY Parlowood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lanahan Funeral Home - 7401 Belair Rd.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mark Gray	

MEDICAL CERTIFICATION

U.S. DEPARTMENT OF JUSTICE

1948

100

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02542

2556 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>				TOWN <u>English Consul</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>				STREET ADDRESS (If rural give location) <u>3608 Annapolis Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM S. DIXON</u>				4. DATE OF DEATH <u>Mar. 17, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 12, 1875</u>	
				9. AGE last birthday <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
13. FATHER'S NAME <u>James Dixon</u>				14. MOTHER'S MAIDEN NAME <u>---</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-01-6585</u>		17. INFORMANT & ADDRESS <u>Mr. James A. Dixon-Towson, Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Carcinoma of Lung</u>						<u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>---</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>---</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic Heart Disease</u>						<u>5 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 2, 1955</u> to <u>March 17, 1956</u> , that I last saw the deceased alive on <u>March 17, 1956</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Byron Sudann</u>				ADDRESS (Street, city, town, state) <u>5010A Ritchie Hwy. Balto., Md.</u>			
DATE SIGNED <u>March 19, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/19/56</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
24. REC'D BY REGISTRAR <u>March 19, 1956</u>		REGISTRAR'S SIGNATURE <u>F. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickney & Sons - Balto., Md.</u>			

8-11-56

1056

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02543

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>C</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William M. Darden</u> First Middle Last 4. DATE DEATH Month <u>3</u> Day <u>23</u> Year <u>1956</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-25-92</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM HAND</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u> 11. BIRTHPLACE (State or foreign country) <u>N.C.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>SAMUEL</u> 14. MOTHER'S MAIDEN NAME <u>ELIZ. M. GIBSON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Family - Same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calcific Aortic Stenosis</u> <u>42.1.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL <u>Sydney S. Katz</u> EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WALKER CHAPEL</u>			
22d. LOCATION (City, town, or county) (State) <u>DARDEN, N.C.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>MICHAEL FUNERAL HOMES</u> ADDRESS					
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Anne MacRae</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

S. A. H. 1910

1910

1910

2558 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE				STATE MARYLAND COUNTY BALTIMORE			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN ROSEDALE		10 YRS.		TOWN ROSEDALE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
1617 ROSEDALE HEIGHTS AVE.				1617 ROSEDALE HEIGHTS AVE.			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
FRANK NICKOLAS DORN				MARCH 19, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	JULY 5, 1890	65 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if changed)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
GAS STATION MANAGER		AMERICAN OIL CO.		BALTIMORE MD.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE DORN				BARBARA KEMMIT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		215 03 8708		MRS MINNA DORN		SAME.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B)				Sudden			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				2 yrs			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
1955		Carcinoma rt. Lung		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 1, 1956, to March 19, 1956, that I last saw the deceased alive on March 18, 1956, and that death occurred at 11 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
L. Baumgardner M.D.				Baltimore Md		3/19/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE HEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		3/22/56		LORRAINE PARK CEMETERY		WOODLAWN MARYLAND.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
March 22, 1956		Mrs. Edith Surley		HE. RY SANDER & SONS INC.		BALTIMORE MARYLAND.	

1 INSTRUCTIONS TO ATTENDING PHYSICIAN ON HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

Government of India
Government of India

Secretary
to the

1952 Government of India

Ministry of
Education
New Delhi

U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 18 & 21 Film G195 4-6-56 a.s.

MARYLAND STATE DEPARTMENT OF HEALTH

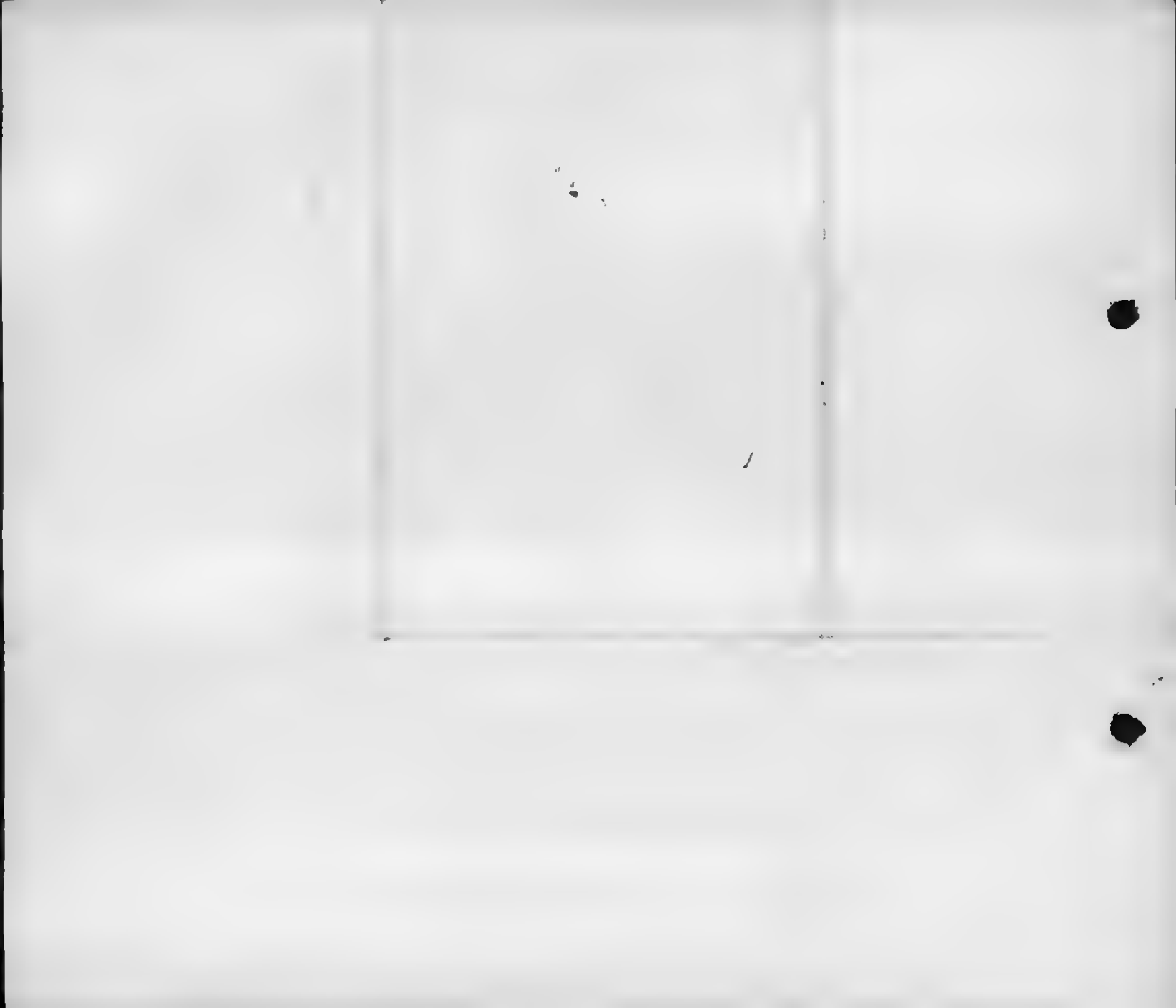
02545

2559

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town) COWSON		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 328 Dixie Drive		STREET ADDRESS (If rural, give location) 328 Dixie Drive	
3. NAME OF DECEASED (First) (Middle) (Last) James P. Dunn		4. DATE OF DEATH (Month) (Day) (Year) Mar. 26 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 16, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Cable Business	9. AGE last birthday 70 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph B. Dunn		14. MOTHER'S MAIDEN NAME Elizabeth Kelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Jas. P. Dunn 328 Dixie Drive			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
903.8 Immediate cause (a) <i>Hypertensive Hemorrhage</i> Antecedent cause(s) (b) <i>II Generalized Arteriosclerosis</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Fractured Hip</i>			<i>2 days</i> <i>10-12</i> <i>7th Mo. 1956</i>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <i>Cape May, N.J.</i>	
TIME (Month) (Day) (Year) (Hour) INJURY Aug 1956 m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? Fell on front porch	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <i>Charles F. Doreen</i>		DATE SIGNED <i>4/16/56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 3/28/56	
NAME OF CEMETERY OR CREMATORY New Cathedral		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE -REG.		24. FUNERAL DIRECTOR <i>W. W. Meeks & Son 805 N. Calvert St.</i>	



may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

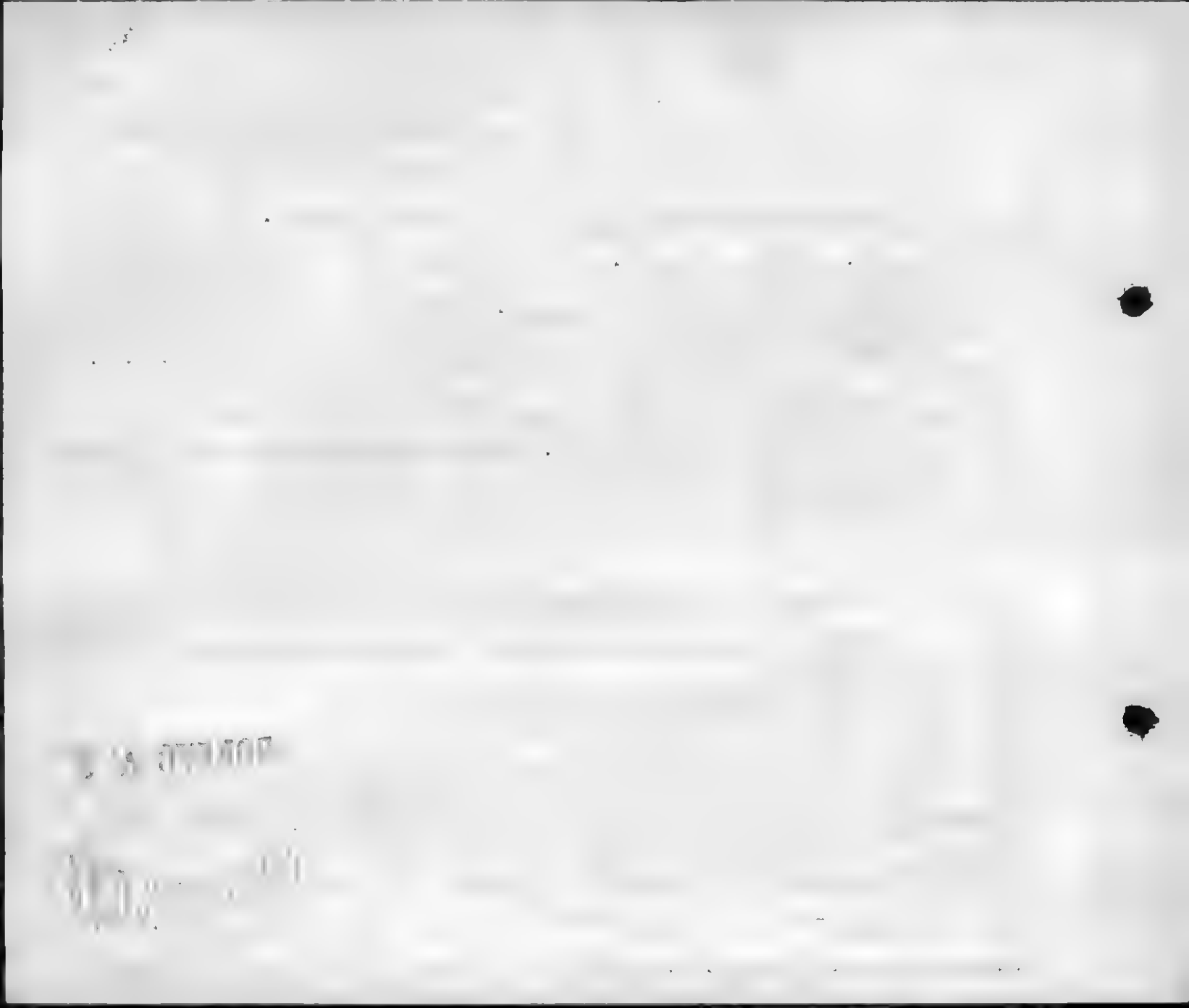
02546

2560

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. LENGTH OF STAY IN 1b Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7606 Queen Anne Drive				e. STREET ADDRESS 7809 Oakdale Ave.			
3. NAME OF DECEASED (Type or print) First Rev. Henry Middle W. Last Ellenberger				4. DATE OF DEATH Month March Day 3 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1873	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Conrad Ellenberger				14. MOTHER'S MAIDEN NAME 1121 Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT W. Leonard Ellenberger-7606 Queen Anne Drive				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Stemmers Run, Balto. Md.				(County) (State)			
21. I certify that I attended the deceased from Peru , 19 53 , to March 3, 19 56 , that I last saw the deceased alive on March 3, 19 56 , and that death occurred at 8 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1116 Chase St. DATE SIGNED							
ACTUAL SIGNATURE Louis Krause M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-1956		22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran		22d. LOCATION (City, town, or county) (State) Stemmers Run, Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Cassidy Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE 3 1956	
				24b. REGISTRAR'S SIGNATURE Dr. R. M. Bacon			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

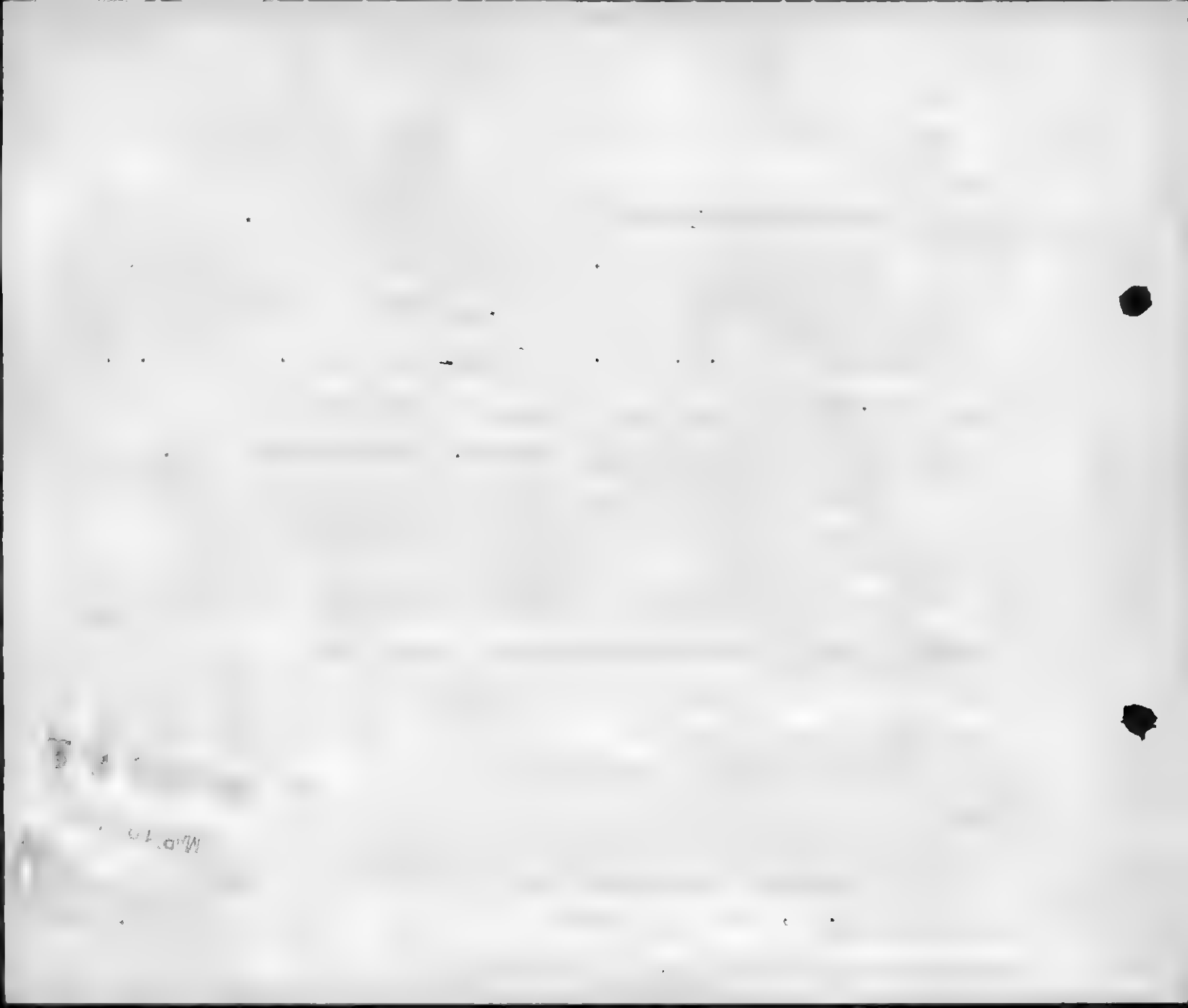
02547

2551

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>				d. STREET ADDRESS <u>4001 Glenmore Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>L.</u> Last <u>England</u>				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1880</u>	
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railway Mail Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>John H. England</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Lewis</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>William J. England-4335 Berger Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic C-V disease</u> DUE TO (c) <u>Pyelo-nephritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>3/12</u> , 19 <u>56</u> , to <u>3/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>56</u> , and that death occurred at <u>5:07</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Tor. H. Sedlack</u>				ADDRESS (Street, city or town, state) <u>200 W. Penna. Ave.</u>			
DATE SIGNED <u>3/16/56</u>				M.D. <u>Towson, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Mar. 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Maryland.</u>				22e. (State)		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>Mabel Graye</u>	
24b. REGISTRAR'S SIGNATURE				DATE		24c. (County)	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2514 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>DUNDALK</u> COUNTY <u>MD.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3527 DUNHAVEN</u>		STREET ADDRESS (If rural, give location) <u>3527 DUNHAVEN RD</u>	
3. NAME OF DECEASED (Type or Print) <u>SOPHIA</u> (First) <u>FEDORCZYK</u> (Last)		4. DATE OF DEATH <u>3</u> (Month) <u>20</u> (Day) <u>1956</u> (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11/16/1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>S</u>		14. MOTHER'S MAIDEN NAME <u>SOPHIA CHMIEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NO</u>	
17. INFORMANT AND ADDRESS <u>STELLA KOVAK, 3527 DUNHAVEN RD</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebral hemorrhage</u>		<u>1 day</u>	
Antecedent cause(s) (b) <u>hypertension, cardiovascular disease, generalized arteriosclerosis</u>		<u>3-4 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3-12, 1956, to 3-19, 1956, that I last saw the deceased alive on 3-19, 1956, and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

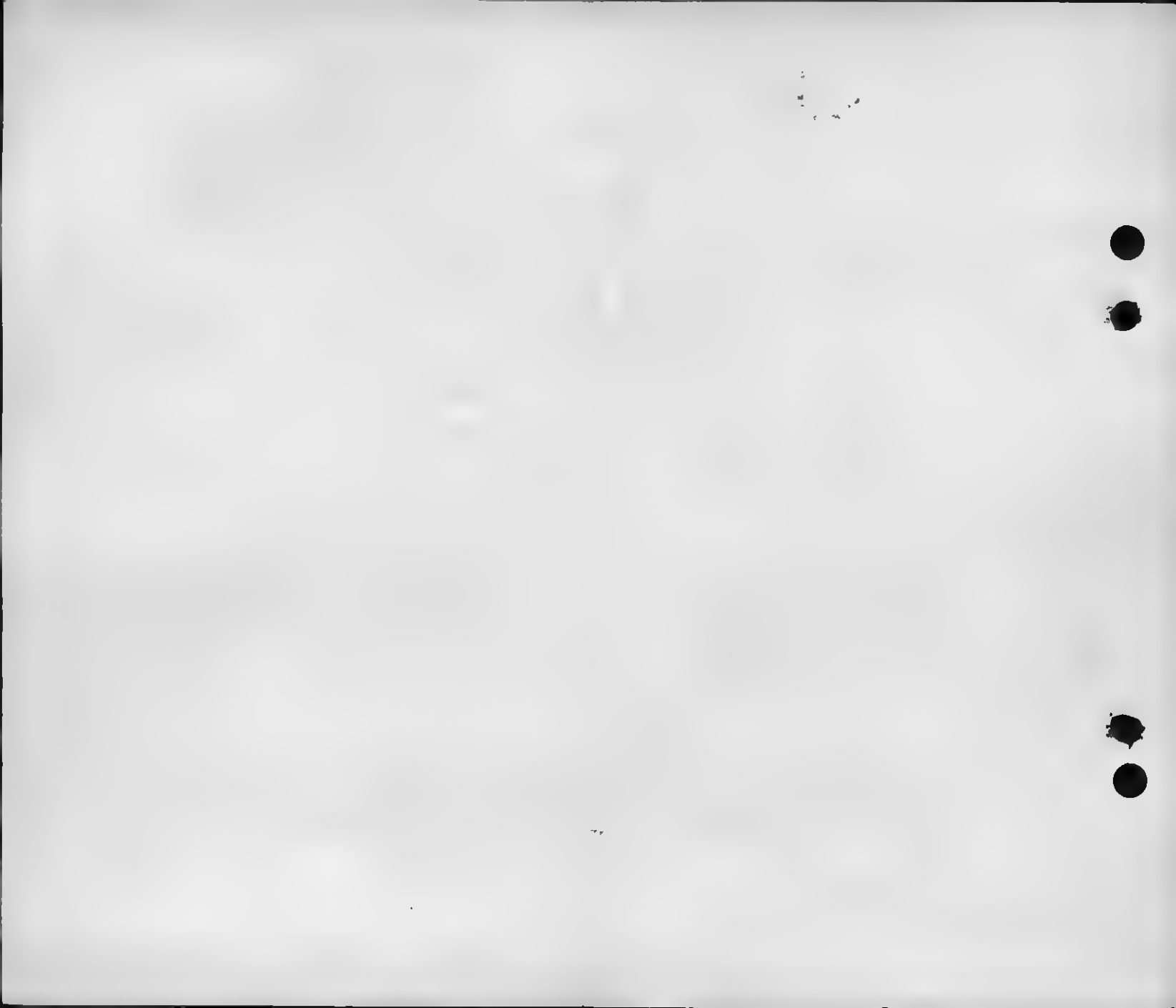
ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3-20-56</u>	<u>A. M. Hedrick</u>	<u>Walter Dabrowski</u>	<u>10014 Dundalk Ave. Baltimore 24 md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1 executed within **24** hours after death.

TO ATTENDING PHYSICIAN OF HOSPITAL The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-58 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02549

2515

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>26 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK (22)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2909 DUNDALK AVE</u>				STREET ADDRESS (If rural give location) <u>2909 DUNDALK AVE.</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE EARL FENNELL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAR. 14, 1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 29, 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TURN FERRMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFG.</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>ANTHONY FENNELL</u>				14. MOTHER'S MAIDEN NAME <u>KILLIE FLEMING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-07-0178</u>		17. INFORMANT & ADDRESS <u>VIOLA D. FENNELL - SAME ADDRESS</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
440x IMMEDIATE CAUSE (A) <u>Hypertensive Cardio-Vascular</u>				INTERVAL BETWEEN ONSET AND DEATH <u>340</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Renal Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 1955</u> to <u>March 14, 1956</u> , that I last saw the deceased alive on <u>March 14, 1956</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above							
SIGNATURE <u>W. J. Davis M.D.</u>				ADDRESS (Street, city, town, state) <u>Dundalk, Md.</u> DATE SIGNED <u>3/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-17-56</u>		NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>		LOCATION (City, town, or county) (State) <u>HOWARD Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Fisher</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter P. Bradley</u>		ADDRESS <u>Dundalk, Md.</u>	
DATE							



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02550

2562 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		LENGTH OF STAY (in this place) <u>45yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bernoudy Rd.</u>				STREET ADDRESS (If rural give location) <u>Bernoudy Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Ellen</u> (Last) <u>Fogle</u>				(Month) <u>May</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>1-31-1867</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas O'Keefe</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not k.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Miss Lillian H. Fogle, White Hall, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-Sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Arterio-Sclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1956</u> to <u>May 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>56</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>G. M. France</u> M.D.				ADDRESS (Street, city, town, state) <u>Jackson Md</u> DATE SIGNED <u>3/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>3-8-56</u>	NAME OF CEMETERY OR CREMATORY <u>St. Josephs Catholic</u>		LOCATION (City, town, or county) <u>Texas, Md.</u>		(State)	
24. REC'D BY REGISTRAR DATE <u>3-8-56</u>	REGISTRAR'S SIGNATURE <u>W. Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brooks</u>		ADDRESS <u>Sparks, Md.</u>		

U.S. AIR FORCE

1956

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH

02551

2563

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>LUTHERVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>802 MORRIS AVE.</u>		STREET ADDRESS (If rural, give location) <u>809 MORRIS AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JAMES</u> (Middle) <u>WILLIAM</u> (Last) <u>FRASER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MAR. 18 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>MAY 19, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WESTERN ELECTRIC</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>	
13. FATHER'S NAME <u>Thomas Fraser</u>		14. MOTHER'S MAIDEN NAME <u>Beessie McKenzie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Jas. W. Fraser, Lutherville, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>MYOCARDIAL INFARCTION</u> Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)		<u>1 min.</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐

SIGNATURE <u>William A. Pillsbury M.D.</u>	(Degree or title)	ADDRESS <u>Timonium</u>	DATE SIGNED <u>3/18/56</u>
23. RIAL CREMATION (Date, place, by)	DATE THEREOF <u>Mar. 23, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
CREMATED BY LOCAL REGISTRAR'S SIGNATURE <u>March 23, 1956</u>	<u>Anne MacRae</u>	24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

U.S. AIR FORCE

1001



2554

CERTIFICATE OF DEATH

Reg. Dist. No.

33-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd.</u>				d. STREET ADDRESS <u>York Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles M. Frederick</u>				4. DATE OF DEATH Month Day Year <u>March 12 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 3, 1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Elvina Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-6878</u>		17. INFORMANT Name <u>Wirtia Frederick</u> Address <u>Parkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate with metastases</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____				20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from <u>Mar. 12</u> , 19 <u>56</u> , to <u>Mar. 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar. 11</u> , 19 <u>56</u> , and that death occurred at <u>9 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>A. M. France</u> M.D. <u>Parkton, Md.</u> NAME (Type) <u>A. M. FRANCE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>White Hall</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>3/13/56</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Preston</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

APR

REC-1

2565

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Parkville</u>				OR TOWN <u>Parkville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3039 Woodside Ave.</u>				STREET ADDRESS (If rural give location) <u>3039 Woodside Ave.,</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
RUDOLF FROHLICH				March 7 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:		IF UNDER 1 YEAR IF UNDER 24 HRS.	
male	white	separated	Mac. 23, 1887	68	yrs.	Months	Days
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Carpenter						Austria	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Unknown				Unknown			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
no				Charles R. Frohlich, son, above			

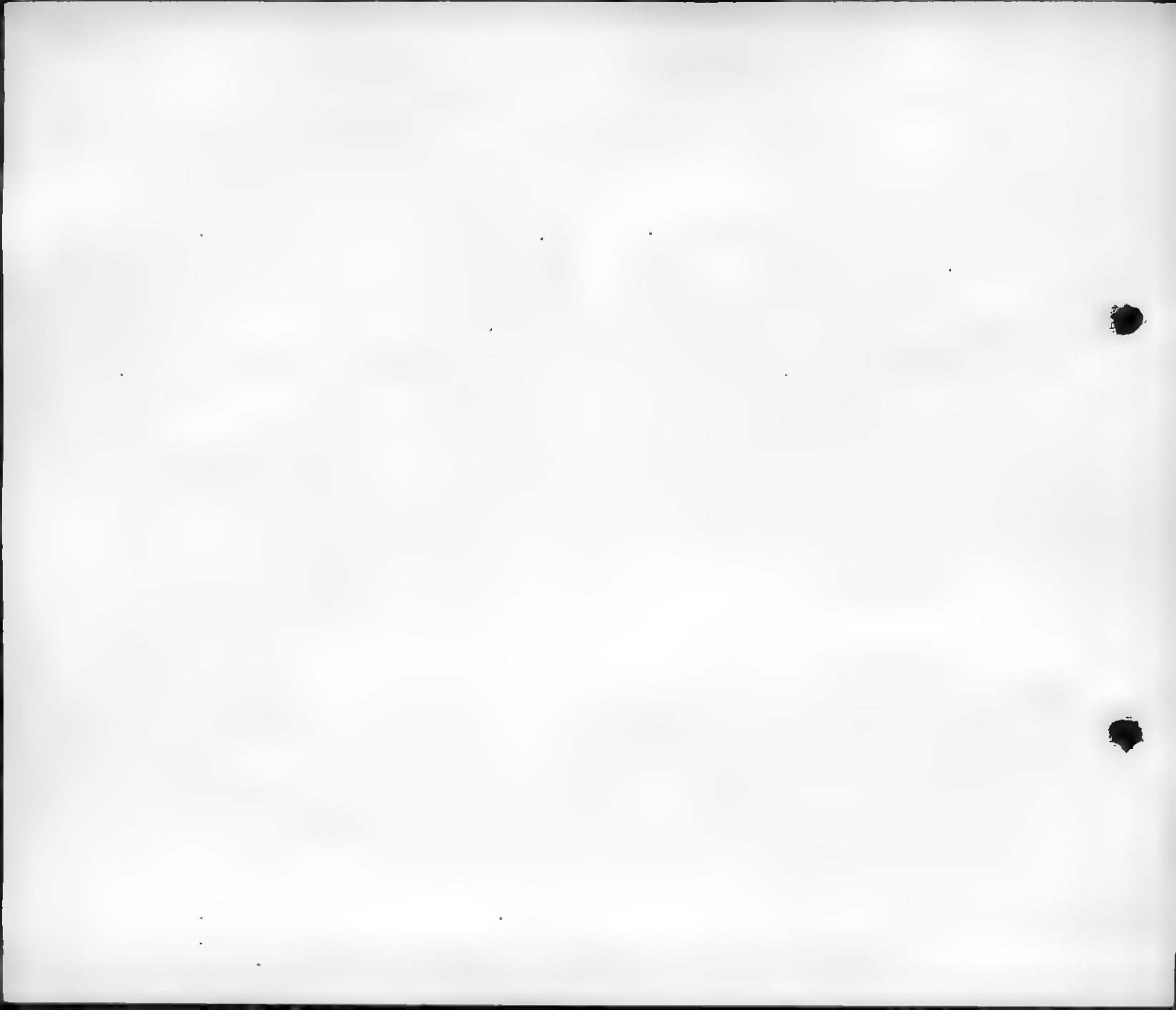
18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) <u>Coronary Thrombosis</u>		15 Minutes
Antecedent causes (s) (b) <u>Cerebral Accidents</u>		7 Months
(c)		

11. OTHER SIGNIFICANT CONDITIONS		12. CITIZEN OF WHAT COUNTRY?	
Conditions contributing to the death but not related to the disease or condition causing death.		U.S.	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY ?	
PLACE (Home, farm, factory, street, office bldg., etc.)		Yes <input type="checkbox"/> No <input type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from <u>N.Y.</u> , 19 <u>55</u> , to <u>March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 5</u> , 19 <u>56</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
<u>Harold H. Burns</u>		<u>8106 Harbor Bld.</u>	
(Degree or title)		DATE SIGNED	
<u>M.D.</u>		<u>March 9, 1956</u>	
23. BURIAL, CREMATION, REMOVAL, (Specify)		NAME OF CEMETERY OR CREMATORY	
Burial		Oak Lawn Cem.	
DATE THEREOF		LOCATION (City, town, or county) (State)	
March 10, 1956		Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
March 9, 1956		Schimunek Funeral Home, Inc.	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>[Signature]</u>		2601-3-5 E. Madison St.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2566

CERTIFICATE OF DEATH

02554
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1912 CECIL AVENUE			
3. NAME OF DECEASED (Type or print) GEORGE D. GAINES				4. DATE OF DEATH MARCH 19 1956			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-99	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LEGAL CLEANER				10b. KIND OF BUSINESS OR INDUSTRY RAG & PAPER CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME GEORGE GAINES			
14. MOTHER'S MAIDEN NAME LAURA CHASE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W.I.			
16. SOCIAL SECURITY NO 218 18 5473				17. INFORMANT CLT. REC. VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MARCH 17 , 19 56 , to MARCH 19 , 19 56 , that I was the attending physician, and that death occurred at 1:12 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FT. HOWARD, MD DATE SIGNED 3/19/56 ACTUAL SIGNATURE F. S. Dickey M.D. PHYSICIAN'S NAME (Type) FRANCIS D. DICKY M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-22-56		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Locks, Jr.				24a. REC'D BY REGISTRAR March 22, 1956 24b. REGISTRAR'S SIGNATURE Dawson L. Furberg			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. F.

1918

1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2567

CERTIFICATE OF DEATH

02555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <u>md</u> <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> <u>McWASHINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6719 BROADVIEW Rd.</u>		d. STREET ADDRESS <u>2007 Smith AVE</u>	
3. NAME OF DECEASED (Type or print) <u>DELLA F GAMBRILL</u> First Middle Last		4. DATE OF DEATH Month <u>MARCH</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 13-1884</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM NAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA CURTIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>6-786 GAMBRILL</u>	
17. INFORMANT <u>CE. RGE GAMBRILL</u>		Address <u>2007 Smith AVE</u> <u>McWASHINGTON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis & auricular fibrillation</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>5 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1951</u> , to <u>Mar 20</u> , 1956, that I last saw the deceased alive on <u>Mar 19</u> , 1956, and that death occurred at <u>8:15 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold H Burns</u> M.D.		ADDRESS (Street, city or town, state) <u>115 E. Cager St.</u> DATE SIGNED <u>3-21-56</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-23-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FALLS Rd METHODIST</u>	22d. LOCATION (City, town, or county) (State) <u>BUTLER BALTO. md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank W Setz</u>		ADDRESS <u>814 W 36 St Balto 11 Md</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Dorothy Newell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. In plain language remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. DUNN

1956

1000

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02556

2568 CERTIFICATE OF DEATH

Reg. Dist. No. *44*

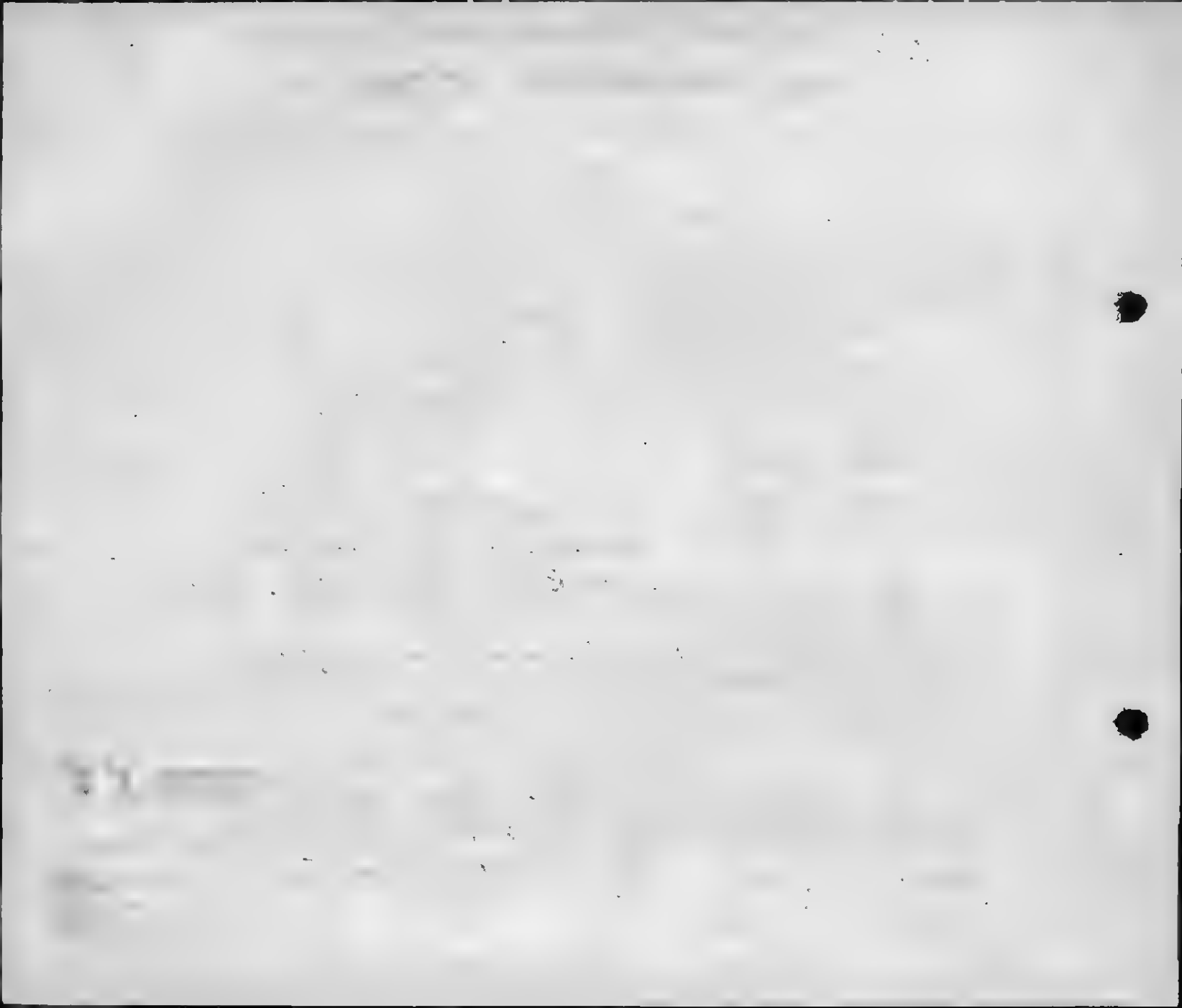
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>BALTO.</i>		MARYLAND		STATE <i>3</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>DUNDALK 22</i>		<i>3 mo.</i>		TOWN <i>45 ME</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>242 RIVERVIEW AVE</i>				STREET ADDRESS (If rural give location) <i>#1</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>FLORENCE ROCK GARRETT</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>3-13-1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>MARRIED</i>	8. DATE OF BIRTH <i>NOV. 30, 1881</i>	9. AGE last birthday <i>74</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>FREDK. GARRETT</i>				14. MOTHER'S MAIDEN NAME <i>ANNA (JOHNSON?)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT & ADDRESS <i>HERMAN GARRETT - SAME</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <i>Generalized Carcinoma</i>				<i>2 mos.</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Adeno Carcinoma of the colon</i>				<i>3 mos.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Hypertension Cardiovascular disease</i>				<i>5 yrs</i>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb 9</i> , 19 <i>56</i> , to <i>Mar 13</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>March 13</i> , 19 <i>56</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Eugene F. Nevey</i>				ADDRESS (Street, city, town, state) <i>M.D. 7001 Mornington Rd Dundalk, Md</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>3/16/1956</i>		NAME OF CEMETERY OR CREMATORY <i>CAH LAWN</i>		LOCATION (City, town, or county) (State) <i>BALTO. Co. MD</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Bruce Bradley, Dundalk, Md</i>		ADDRESS	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2569

CERTIFICATE OF DEATH

Reg. Dist. No.

02557

43

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Belhaven Drive				d. STREET ADDRESS 14 Belhaven Drive			
3. NAME OF DECEASED (Type or print) Mrs. Filippina First Middle <i>Ann</i> Last <i>Giannetta</i>				4. DATE OF DEATH Month March Day 12th Year 1956			
5 SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1884	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 12 Days 12 Hours 56	IF UNDER 24 HRS Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Joseph Ferrari				14. MOTHER'S MAIDEN NAME Margaret Greco			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. John Arena, 14 Belhaven Drive, #6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4222 DUE TO Coronary Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Regeneration DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/2/1956 , to 3/11/1956 , that I last saw the deceased alive on 3/11/1956 , and that death occurred at 10:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Max Dussin		M.D. 1927 York Rd, TIMONUM		ADDRESS (Street, city or town, state)		DATE SIGNED 3/12/56	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 15, 1956		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery Asso.		22d. LOCATION (City, town, or county) (State) Irvington, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14				24a. REC'D BY REGISTRAR DATE 3/14/56		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Reifson	

100-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2570

CERTIFICATE OF DEATH

02558

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2508 Taylor Avenue		d. STREET ADDRESS 2508 Taylor Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Mr. Henry W. Gleim		4. DATE OF DEATH Month Day Year March 20th 1956	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1883
9. AGE (In years last birthday) yrs 72		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype Machinist		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles F. Gleim		14. MOTHER'S MAIDEN NAME Emma Kohlman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-2638	
17. INFORMANT Mrs. Katherine W. Gleim, 2508 Taylor Ave #14		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma w/ extensive metastases 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Anemia severe			
INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 1954, to 20 March , 1956, that I last saw the deceased alive on 20 March , 1956, and that death occurred at 11:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward L. J. Meitz M.D.		ADDRESS (Street, city or town, state) 7425 Harford Rd. DATE SIGNED 21 March 56	
PHYSICIAN'S NAME (Type) EDWARD L. J. MEITZ M.D.		Baltimore Md	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/24/56	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE 1956	
		24b. REGISTRAR'S SIGNATURE Dr. R. M. Bacon	

52

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2571 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02559

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gray Manor</u> c. LENGTH OF STAY IN lb <u>30 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2702 Old North Point Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gray Manor</u> d. STREET ADDRESS <u>2702 Old North Point Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <u>LEROY</u> Middle <u>H.</u> Last <u>GODWIN</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1956</u>																			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 10, 1894</u>		9. AGE (In years last birthday) <u>61</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Concrete Products - manufacturer Harford Co., Md.</u>								10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Benjamin J. Godwin</u>								14. MOTHER'S MAIDEN NAME <u>Kate A. Hooker</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>---</u>				17. INFORMANT Address <u>Gladys H. Godwin, 2702 Old North Point Rd.</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>															
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <u> </u> Not while <u> </u> at work <input type="checkbox"/> Not at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.																							
ACTUAL SIGNATURE <u>M. B. Davis</u>								EXAMINER'S NAME (Type) <u>M. B. DAVIS</u>								DATE SIGNED <u>3/15/56</u>							
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>burial</u>								22b. DATE THEREOF <u>3/17/56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook, Inc.</u>								ADDRESS <u>1217 St. Paul Street</u>								24a. REC'D BY REGISTRAR <u> </u>				24b. REGISTRAR'S SIGNATURE <u> </u>			

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G193 3-6-56 et

2572

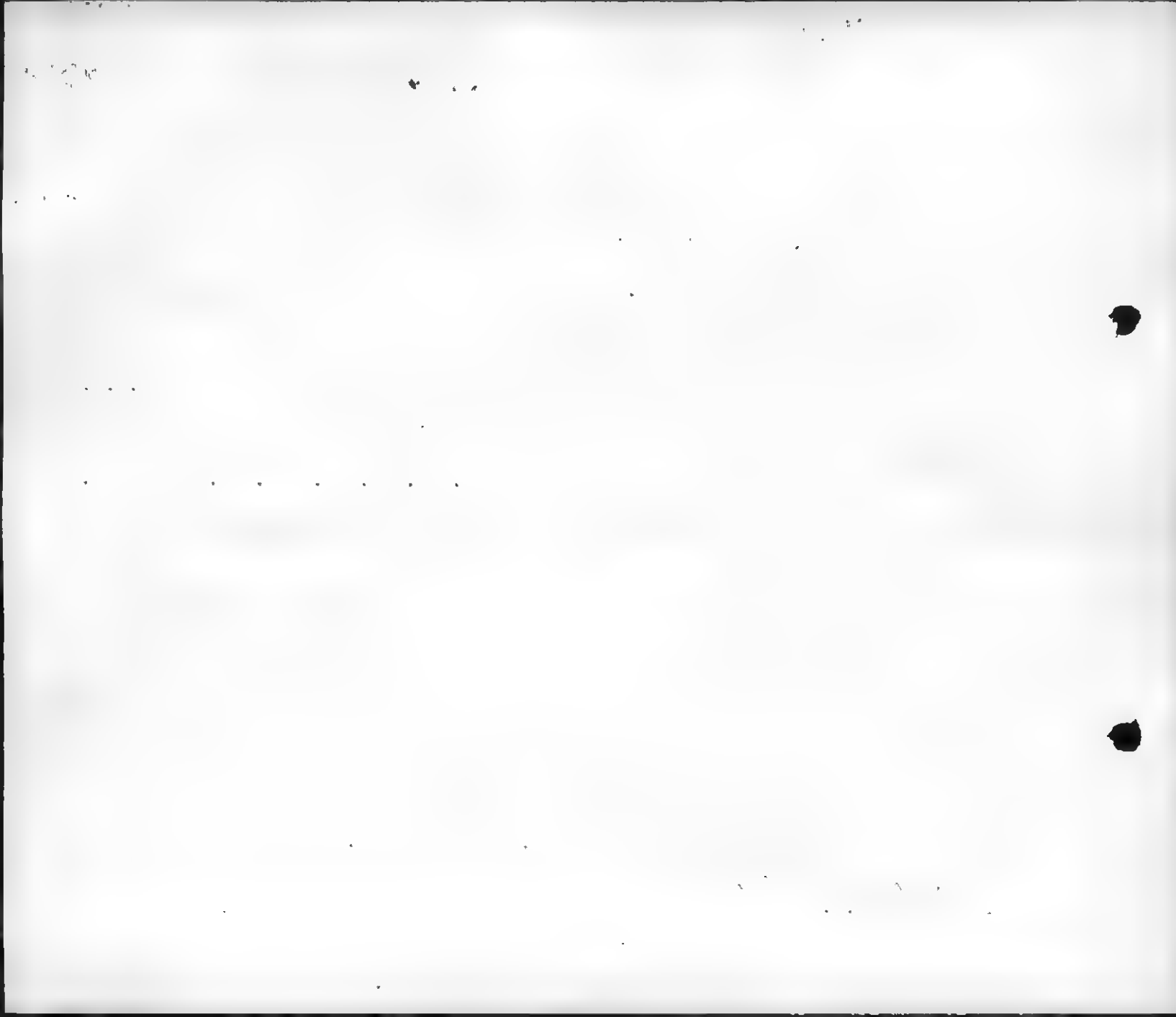
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>V.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>66 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>107 Purnell Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WINFRED W. GOSWELLIN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 4 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>7/21/24</u>
9. AGE last birthday: <u>31</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Snow Hill, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Clarence Goswellin</u>		14. MOTHER'S MAIDEN NAME: <u>Cynthia Hearne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>Korean</u>		16. SOCIAL SECURITY NO.: <u>214 18 4314</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>RETICULUM CELL SARCOMA</u>			UNKNOWN
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20C. WHERE DID (City or town) (County) (State)		20D. HOW DID INJURY OCCUR?	
21A. TIME (Month) (Day) (Year) (Hour) OF INJURY		21B. INJURY OCCURRED While at work Not while at work	
22. I hereby certify that I attended the deceased from <u>Dec. 29, 1955</u> , to <u>Mar. 4, 1956</u> and that death occurred at <u>12:25 M.</u> from the causes and on the date stated above.			
C. GONZALEZ, M.D.		VAH, FORT HOWARD, MD.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-4-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Whitcote Cemetery</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Clarence E. Dennis Funeral Home</u>		ADDRESS <u>Snow Hill, Maryland</u>	

02560

0-2560



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02561

2573

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>				TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Roberts Avenue</u>				STREET ADDRESS (If rural give location) <u>10 Roberts Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Oliver Harrison Gray</u>				OF DEATH: <u>3</u> <u>20</u> <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>6/1/1884</u>	
9. AGE last birthday <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months Days		11. IF UNDER 24 HRS: Hours Min.			
10A. USUAL OCCUPATION (Give kind of done during most of working life, if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Janitor</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>George H. Gray</u>				14. MOTHER'S MAIDEN NAME: <u>Harriett</u> ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				17. INFORMANT & ADDRESS: <u>Mrs. Sadie Gray - 10 Roberts Avenue</u>			
16. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardio Vascular Renal Disease - Hypertensive</u>				1 yr.			
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>54</u> , to <u>March</u> , 19 <u>56</u> , that I last saw the deceased on <u>March 18</u> , 19 <u>56</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>600 N. Arlington Ave.</u>		DATE SIGNED <u>3/23/56</u>	
23. BURIAL, CREMATION, OR REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/24/56</u>		NAME OF CEMETERY OR CREMATORY <u>Liberty Cemetery</u>		LOCATION (City, town, or county) (State) <u>Liberty, Maryland</u>	
24. REC'D BY LOCAL REGISTRAR <u>3-23-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Elroy O. Wilson</u>		ADDRESS <u>1000 Brantley Ave</u>	

00200

2574

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 11 mos. 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Spring Grove State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 3520 Hilton Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Grebe		4. DATE OF DEATH March 7, 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1868
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Grebe		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right pyelitis and lithiasis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-23 , 19 55 , to 3-7 , 19 56 , that I last saw the deceased alive on 3-7 , 19 56 , and that death occurred at 3:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE T. Glyne Williams		ADDRESS (Street, city or town, state) Spring Grove State Hospital, Catonsville 28, Maryland	
PHYSICIAN'S NAME (Type) T. Glyne Williams, M. D.		DATE SIGNED 3-7-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 10, 1956	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE 3 1956	
		24b. REGISTRAR'S SIGNATURE	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9755

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
2575 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 02563										
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			c. LENGTH OF STAY IN 1b <u>8 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. IRVENESS</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2802 Lingamore Road</u>					d. STREET ADDRESS <u>1918 Kelmore Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Phyllis</u> Middle <u>Griffith</u> Last <u>Griffith</u>					4. DATE OF DEATH Month <u>3</u> - Day <u>9</u> - Year <u>1956</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 20 - 1930</u>		9. AGE (In years last birthday) <u>25</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>RALPH - R - ROSIER</u>					14. MOTHER'S MAIDEN NAME <u>GLADYS BAKER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-26-1109</u>		17. INFORMANT <u>ELLWOOD R. GRIFFITH - W. IRVENESS</u> Address <u>1918 Kelmore Rd</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <u>P</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>William Griffith</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)			
<u>BURIAL</u>		<u>3-13-56</u>		<u>Green Grove</u>			<u>Rayville Beltsville MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Seitz</u>					ADDRESS <u>814 N. 31st St Baltimore City, MD</u>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

EDWARD V. H.

MAR

11

2576

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland, U.S.A. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point d. STREET ADDRESS 20 Denton Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nettie Middle Hartmann Last Hartmann		4. DATE OF DEATH Month March Day 31 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-1894
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Gurlach		14. MOTHER'S MAIDEN NAME Minnie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Hospital Records		Address Mt. Wilson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/27 , 19 56 , to 3/31 , 19 56 , that I last saw the deceased alive on 3/31 , 19 56 , and that death occurred at 2.30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED William Newcomer ACTUAL SIGNATURE WM. NEWCOMER, M. D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 2, 1956	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR DATE 3 1956	
24b. REGISTRAR'S SIGNATURE Dorothy Newell			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital for attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2577

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN Ib 8yr4mos25days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle T. Last Harvey		4. DATE OF DEATH Month March Day 27 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-1877
9. AGE (In years last birthday) yrs 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tyus Taylor		14. MOTHER'S MAIDEN NAME Anna Salter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7- 19 53 , to 3-27- 19 56 , that I last saw the deceased alive on 3-27- 19 56 , and that death occurred at 8:20P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. Spring Grove State Hospital 3-28-56			
22. ACTUAL SIGNATURE Stella Wachslar M.D. Spring Grove State Hospital 3-28-56			
23. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Buried		3/29/56	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Univ. Md. Med. School		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
		APR 21 1956	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUENDY V. B.

1000 1000 1000

2578

CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Colgate</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Colgate</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7603 Riddle Ave.</u>		STREET ADDRESS (If rural give location) <u>7603 Riddle Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MAMIE</u> <u>HAYNES</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>March 14, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 12, 1877</u>
9. AGE last birthday: <u>78</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John White</u>		14. MOTHER'S MAIDEN NAME: <u>Maria Davies</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY No.: <u>Archie Haynes 7603 Riddle Ave.</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>592X</u> Immediate cause (a) <u>Uremia</u> Antecedent causes (s) (b) <u>Chronic Interstitial Nephritis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Hy perension</u>		Interval Between Onset And Death <u>10</u> <u>1 year</u> <u>10 years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		12. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION: <u>3/14</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		20. PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) <u>Colgate, Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3/14</u> <u>1956</u> <u>7:30 PM</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>June 1955</u> to <u>March 14, 1956</u> , that I last saw the deceased alive on <u>3/14</u> , 1956, and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.		23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
SIGNATURE (Degree or title) <u>Morris G. Jacobson MD</u>		DATE SIGNED <u>3/15/56</u>	
24. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar. 17, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		LOCATION (City, town, or county) (State) <u>Colgate, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>MAR 19 1956</u>		FUNERAL DIRECTOR <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>	

RECEIVED
JAN 10 1964
U. S. AIR FORCE

2579

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1412 Regester Avenue				d. STREET ADDRESS 1412 Regester Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Patricia Lynn Hays				4. DATE OF DEATH Month Day Year March 28 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1951		9. AGE (In years last birthday) yrs 4		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard U. Hays				14. MOTHER'S MAIDEN NAME Nancy Lee Maglidt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Richard U. Hays (Father) 1412 Regester Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis DUE TO (c) Nephrosis INTERVAL BETWEEN ONSET AND DEATH 3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May , 1953, to Mar 28 , 1956, that I last saw the deceased alive on Mar 28 , 1956, and that death occurred at 4 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Harriet G. Guild M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Johns Hopkins Hospital			
PHYSICIAN'S NAME (Type) Harriet G. Guild							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/31/56		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leonard J. Ruck, 5305 Harford Road #14				24a. REC'D BY REGISTRAR April 2, 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must sign the certificate. After the certificate has been signed by the attending physician and coroner, it must be filed in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and coroner, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Journal of Management Education 32(1)

1000

2580 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8, Film (19), 1-2-56 et.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> , Sparrows Point c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Co. Dispensary</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3830 Falls Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Franklin</u> Last <u>Henderson</u>				4. DATE OF DEATH <u>3-1-56</u> Month <u>3</u> Day <u>1</u> Year <u>19</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u> <u>July 2, 1891</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Fireman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Henderson.</u>				14. MOTHER'S MAIDEN NAME <u>Dora Phillips.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Bessie G. Henderson. 3830 Falls Road.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. Davis, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>March 3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's, Hampden</u>		22d. LOCATION (City, town, or county) (State) <u>3900 Roland Ave, Balto, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hester E. Landon - 3819 Roland Ave</u>				24a. REC'D BY REGISTRAR <u>Dawson L. Furber</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Furber</u>	
				DATE <u>Balto., Md.</u>			

5 1/2 miles

2581

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Upperco</u>		LENGTH OF STAY (in this place) <u>5 Wks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Upperco</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Upperco, M& R.F.D. #1</u>				STREET ADDRESS (If rural give location) <u>R.F.D. #1 Upperco, M&</u>			
3. NAME OF (First) (Middle) (Last) <u>ANNA M. Henry</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 30</u> 19 <u>56</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Sept. 22, 1885</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>- - - -</u>		9. AGE last birthday <u>70</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Baltimore, M&</u>	
13. FATHER'S NAME: <u>Lawrence Sands</u>				14. MOTHER'S MAIDEN NAME: <u>Mary White</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Lawrence Henry - Upperco, M& - R.F.D. #1</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>3 days</u>	
ANTECEDENT CAUSE (B) <u>Cerebral Arterio-Sclerosis</u>						<u>4-5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 5, 1955</u> , to <u>March 30, 1956</u> , that I last saw the deceased alive on <u>March 29, 1956</u> , and that death occurred at <u>109 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. C. Porterfield</u>				ADDRESS <u>Stamptown, M&</u>		DATE SIGNED <u>3-30-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Stephen's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bradshaw, M&</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 31, 1956</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>John A. Moran</u>		ADDRESS <u>3000 E. Baltimore St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2532

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Balto</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pikesville</i>	LENGTH OF STAY (in this place) <i>9 mo.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Kensington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Robt Herring Home Essex Rd.</i>		STREET ADDRESS (If rural give location) <i>4304 Kensington Rd.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>ANNA M. Herget</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Mar 30 1956</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>3-24-1885</i>
		9. AGE last birthday: <i>71</i> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Amusements</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Home</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME: <i>Karl Maag</i>	
14. MOTHER'S MAIDEN NAME: <i>Lena Schroeder</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>No</i>	
16. SOCIAL SECURITY NO.: <i>none</i>		17. INFORMANT & ADDRESS: <i>Mrs. Henry Spatis, Stevenson P.O. Md.</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Cerebral vascular accident</i>			<i>6 wks.</i>
ANTECEDENT CAUSE (B) <i>Arteriosclerotic heart disease</i>			<i>3 yrs.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>none</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 1, 1955</i> , to <i>30 Mar, 1956</i> , that I last saw the deceased alive on <i>29 Mar, 1956</i> , and that death occurred at <i>10A M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Paul H. Korge</i>		ADDRESS <i>Pikesville 8 Md.</i>	
DATE SIGNED <i>30 Mar 56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>4/2/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Western</i>		LOCATION (City, town, or county) (State) <i>Edmondson Ave. Balto, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4-2-56</i>		REGISTRAR'S SIGNATURE <i>Harold A. Newell</i>	
24. FUNERAL DIRECTOR		ADDRESS <i>Frank H. Powell, Pikesville, Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED N. B.

APR

1950

2533

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale				c. LENGTH OF STAY IN IB Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8339 Phila. Rd.				d. STREET ADDRESS 8339 Phila. Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Albert A. Herrmann				4. DATE OF DEATH March 15, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23, 1893	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR 7 Months		IF UNDER 24 HRS 15 Hours		IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Milk Bar		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Edward Herrmann				14. MOTHER'S MAIDEN NAME Emma Neumeister			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-28-1525		17. INFORMANT Mrs. Myrtle C. Herrmann-8339 Phila. Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of the pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 mos							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore (County) Baltimore (State) Md.							
21. I certify that I attended the deceased from 8/27/55 , 19 55 , to 3/15/56 , 19 56 , that I last saw the deceased alive on 3/15/56 , 19 56 , and that death occurred at 2:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8017 Philadelphia Ave., Balto., Md. DATE SIGNED George D. Edwards							
ACTUAL SIGNATURE George D. Edwards M.D.				PHYSICIAN'S NAME (Type) George D. Edwards, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 18, 1956		22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran		22d. LOCATION (City, town, or county) (State) Stemmers Run, Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lansahn Funeral Home - 7401 Belair Rd. ADDRESS 7401 Belair Rd.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mrs. Edith L. Lundy	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. The attending physician and the funeral director must sign the certificate. After the certificate is signed, the funeral director should detach page 3 and send it to the funeral director. The funeral director should then detach page 3 and send it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

37

1941

2584

CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt. Wilson				c. LENGTH OF STAY IN 1b 2 1/4 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last IGNATIUS MORTIMER HESTER				4. DATE OF DEATH Month Day Year 3 25 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1884 12-29-1884	
9. AGE in years (last birthday) 66		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME PETER WILLIAM HESTER				14. MOTHER'S MAIDEN NAME EMMY WHEATLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 213-10-1062		17. INFORMANT Address Hospital Records Mt. Wilson, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMPHYSEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) PULMONARY FIBROSIS DUE TO (c) PULMONARY TUBERCULOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO SCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 1 3/4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-26-1954 , to 3-25-1956 , that I last saw the deceased alive on 3-25-1956 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED							
ACTUAL SIGNATURE William Newcomer M.D.				PHYSICIAN'S NAME (Type) WM. NEWCOMER, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR 26 1956		22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ULLRICH FUNERAL HOME 4210 BELAIR				24a. REC'D BY REGISTRAR March 28, 1956		24b. REGISTRAR'S SIGNATURE Veronica Newell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner, if filled in by the funeral director, may be retained by the hospital. After the certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LAND

STATE OF NEW YORK

IN SENATE

January 1, 1902

REPORT

OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

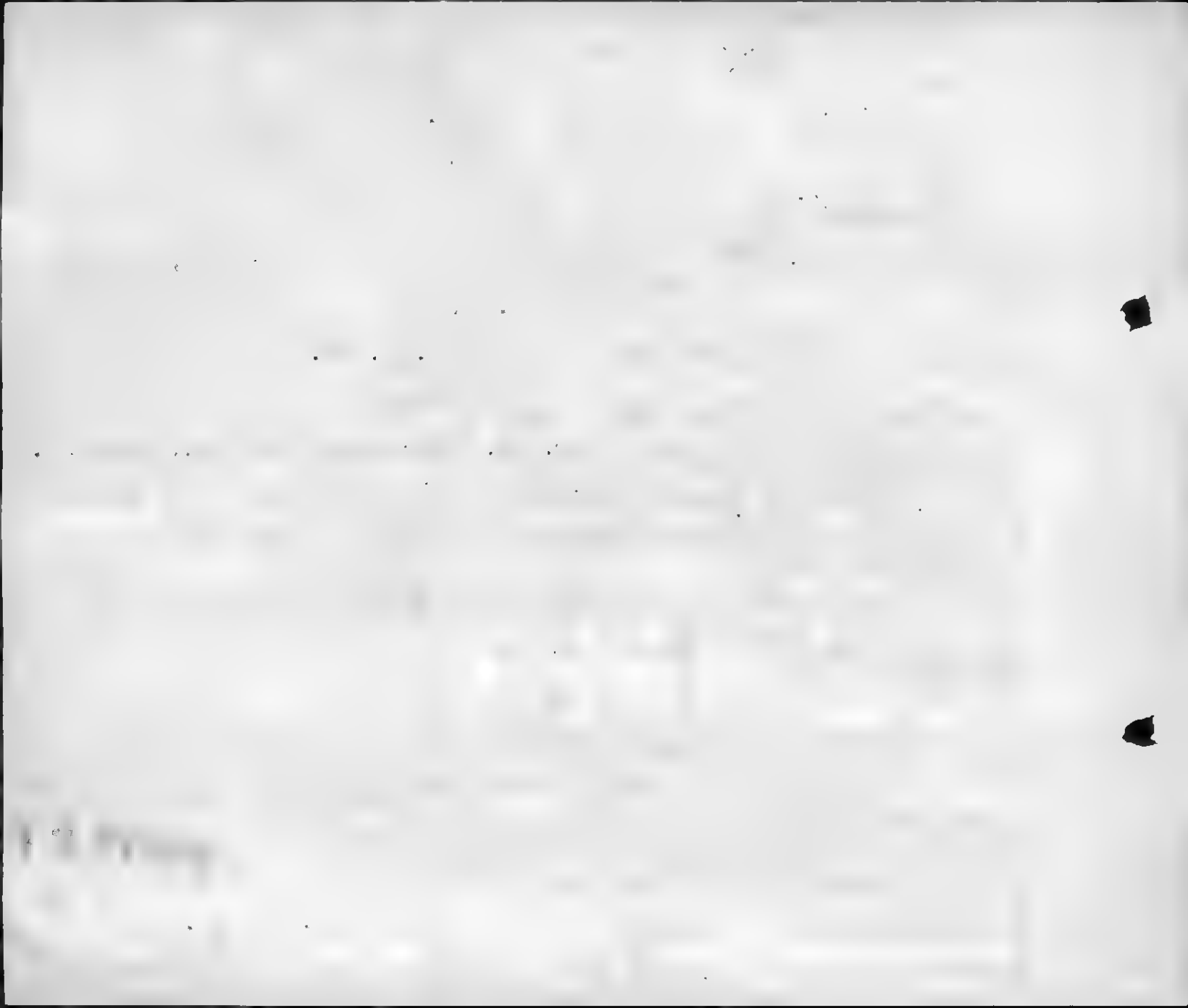
2585

CERTIFICATE OF DEATH

02571

Reg. Dist. No. 40

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm	
d. NAME OF HOSPITAL (If not in hospital, give street address) Stoney Patter Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MYRTLE R. HIENER		4. DATE OF DEATH March 30th, 1956	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1910
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY Own Home	9c. AGE (In years last birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	10c. AGE (In years last birthday) 45 yrs.
11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Drenner		14. MOTHER'S MAIDEN NAME May Sadler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Edw. Hiener, Stoney Batter Rd., Glenarm, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Hypertensive Cardiovascular Dis DUE TO (c) Pulmonary Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 3 mos. 10 yrs. 5 wks.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lung		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 8, 1938 to Mar. 30, 1956 , that I last saw the deceased alive on March 29, 1956 , and that death occurred at 7 P. M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) Fork, Md. DATE SIGNED 3/31/56	
ACTUAL SIGNATURE Clifford F. Hudson		PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON FORK, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/2/56	
22c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		22d. LOCATION (City, town, or county) (State) Belair, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Laasah Funeral Home		24a. REC'D BY REGISTRAR April 2, 1956	
ADDRESS 7401 Belair Road		24b. REGISTRAR'S SIGNATURE Dr. Walter Hammett	



MARYLAND STATE DEPARTMENT OF HEALTH

02572

2411 N. Charles Street, Baltimore

2586

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3219 E Joppa Rd</u>		STREET ADDRESS <u>3219 E Joppa Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LINDA</u>	(Middle) <u>DARLENE</u>	(Last) <u>HILTON</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>OCT 4 1954</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>1</u> yrs.
13. FATHER'S NAME <u>COLEMAN L HILTON</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA VAUGHT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>Barbara Hilton 3219 E. Joppa Rd</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>TAY-SACHS DISEASE</u>			<u>From birth</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Mar 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 9</u> , 19 <u>55</u> , and that death occurred at <u>7 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Belliot James</u>		ADDRESS <u>M.D. 2100 Highland Rd. Balt. 14 Md. 3-126</u>	
DATE SIGNED		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>3-13-56</u>	NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>	LOCATION (City, town, or county) (State) <u>BALTO MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <u>CHARLES EVANS & SON</u>	
		ADDRESS <u>8808 Hartford Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 TDM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02573

2587 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Nunnery Lane</u>				STREET ADDRESS (If rural give location) <u>10 Nunnery Lane</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES ANDREW HOFFNAGLE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 21 19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 7, 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Rhinehardt Hoffnagle</u>				14. MOTHER'S MAIDEN NAME <u>Martha Frank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>World War No. 1</u>		16. SOCIAL SECURITY NO. <u>216-32-6003</u>		17. INFORMANT & ADDRESS <u>Mrs. Mildred H. Hoffnagle</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) DUE TO				<u>Coronary Thrombosis</u>		<u>8 years</u>	
ANTECEDENT CAUSE(S) (B) DUE TO				<u>Coronary Atherosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C) DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-2</u> , 19 <u>48</u> , to <u>3-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-20</u> , 19 <u>56</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leon Ashman</u>		DATE THEREOF <u>3/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		LOCATION (City, town, or county) (State) <u>Catonsville Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>March 23, 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Hickey & Sons - Balt.</u>		ADDRESS <u>1717</u>	

MAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 2588 CERTIFICATE OF DEATH

02574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale				c. LENGTH OF STAY IN 1b 15 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8124 Philadelphia Rd				d. STREET ADDRESS 8124 Philadelphia Rd.			
3. NAME OF DECEASED (Type or print) First Clarence Middle Hoover Last Hoover				4. DATE OF DEATH Month 3 Day 16 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1880	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostler		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jake Hoover				14. MOTHER'S MAIDEN NAME Mary Boone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Catherine M. Hoover-8124 Philadelphia Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 9/25 , 19 53 , to 3/16 , 19 56 , that I last saw the deceased alive on 3/16/56 , 19 56 , and that death occurred at 9:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George D. Edwards M.D. 8019 Philadelphia Rd., Balto., Md. 3/16/56							
22a. BURIAL, CREMAT. OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		3-19-56		Moreland Mem. Park		balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lussahn Funeral Home - 7401 Belair Rd.				24a. REC'D BY REGISTRAR DATE 10 1956		24b. REGISTRAR'S SIGNATURE Mrs. Edith Shirley	



74

MEDICAL CERTIFICATION

VS. A15ME(S)
SM 9/55

OF THE

1875

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

02576

2590

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

1. PLACE OF DEATH COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD. COUNTY BALTO	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN LODGE FOREST 14 LENGTH OF STAY (In this place) 80 YRS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LODGE FOREST	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7740 S. COVE RD.		STREET ADDRESS (If rural, give location) 7740 S. COVE RD.	
3. NAME OF DECEASED (First) OSCAR (Middle) — (Last) HJOPONEN	4. DATE OF DEATH (Month) 3 (Day) 27 (Year) 1952		
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 17, 1891 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL LABORER		10b. KIND OF BUSINESS OR INDUSTRY STEEL MFR	11. BIRTHPLACE (State or foreign country) FINLAND
13. FATHER'S NAME Wm. HJOPONEN		14. MOTHER'S MAIDEN NAME UNK.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, do, or unknown) — (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 213-09-36881	
17. INFORMANT MATILDA L. HJOPONEN		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 10000 Immediate cause (a) Coronary Occlusion Antecedent cause(s) (b) Arteriosclerotic H. D. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) —			INTERVAL BETWEEN ONSET AND DEATH 3 months 5 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m. —		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE Cecil C. Collins M.D.		DATE SIGNED 22 3-28-52	
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE THEREOF 3-27-52	
NAME OF CEMETERY OR CREMATORY DELAIR MEM.		LOCATION (City, town, or county) (State) DELAIR, MD.	
DATE REC'D BY LOCAL REG. —		24. FUNERAL DIRECTOR — ADDRESS —	

3 18. 01. 1901

Ed.

18. 01. 1901

2591

CERTIFICATE OF DEATH

Reg. Dist. No.

2

1. PLACE OF DEATH a. COUNTY Balto MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 m.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS Huntingtown	
3. NAME OF DECEASED (Type or print) First Olen Middle Edward Last Ireland		4. DATE OF DEATH Month 3 Day 26 Year 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10.11.80
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months 1 Days 15 Hours 19 Min. 56	IF UNDER 24 HRS. Months 1 Days 15 Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Ireland		14. MOTHER'S MAIDEN NAME Elisabeth Gibson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Spring Grove Hosp.	
17. INFORMANT Spring Grove Hosp.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic nephrosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 month years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 1.30 p. m. 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3-26		20f. (City or town) 56 (County) (State)	
21. I certify that I attended the deceased from 3-26-56 , 19 56 , to 3-26-56 , 19 56 , that I last saw the deceased alive on 3-26-56 , 19 56 , and that death occurred at 11 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Spring Grove State Hospital	
ACTUAL SIGNATURE Stella Wachslor M.D.		DATE SIGNED 3-27-56	
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 3-29-56	22c. NAME OF CEMETERY OR CREMATORY Emmanuel	22d. LOCATION (City, town, or county) (State) Calvert Co. Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert Hartness		ADDRESS Middle Md	
24a. REC'D BY REGISTRAR March 24, 1956		24b. REGISTRAR'S SIGNATURE V. E. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician must sign the certificate. After the certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2592

CERTIFICATE OF DEATH

02578

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 SPRING GROVE STATE HOSP		d. STREET ADDRESS 413 Allies Road, S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last EDWIN FRED JACKEMEYER		4. DATE OF DEATH Month Day Year MARCH 12 1956	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1905
9. AGE (In years lost birthday) 50 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/> YES MARINES '30-34		16. SOCIAL SECURITY NO. -	
17. INFORMANT Records of Spring Grove State Hosp.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Huntington's Chorea 355x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 30, 1953 , to Mar. 12, 1956 , that I last saw the deceased alive on March 12, 1956 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jerome E. Shapiro M.D.		ADDRESS (Street, city or town, state) Spring Grove Hosp. DATE SIGNED 3/12/56	
PHYSICIAN'S NAME (Type) Baltimore, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Mar. 16, 1956	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Washington, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Wysocki		24a. REC'D BY REGISTRAR DATE 3/13/56	
ADDRESS 1300 N. St. 16		24b. REGISTRAR'S SIGNATURE T. E. Harry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



02579

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2593

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House In The Lines 16 Rusting Ave.</u>		STREET ADDRESS (If rural, give location) <u>10 E. Henrietta St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Margaret Jewell</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>5</u> (Year) <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 23, 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Benjamin Davis</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Estelle Bowden 10 E. Henrietta</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4-4-67 Immediate cause (a) Cerebral embolism

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized arteriosclerosis(c) Functional H. hyp - hypertensiveINTERVAL BETWEEN ONSET AND DEATH
Minutes

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from Dec. 5, 1967 to 2/26, 1968, that I last saw the deceased alive on 2/26, 1968, and that death occurred at 8:20 A.M., from the causes and on the date stated above.

SIGNATURE J. B. Johnson M.D.

(Degree or title)

ADDRESS

DATE SIGNED 3/6/68

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF 3/7/68NAME OF CEMETERY OR CREMATORY Chester Cem.LOCATION (City, town, or county) Chestertown, Md.

(State)

DATE REC'D BY LOCAL REG. 3/6/68REGISTRAR'S SIGNATURE J. B. Johnson

24. FUNERAL DIRECTOR

ADDRESS JOHN F. DENNY, INC. 715 Light St.Baltimore 30, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

executed within 24 hours after death.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02580

2594 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Towson		LENGTH OF STAY (in this place) 45 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 200 E. Joppa Road				STREET ADDRESS (if rural give location) 200 E. Joppa Road			
3. NAME OF DECEASED (Type or Print) (First) GEORGE (Middle) SEYMOUR (Last) JOHNSON				4. DATE OF DEATH (Month) (Day) (Year) March 18, 1956			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 30, 1886	9. AGE last birthday 69 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman		10b. KIND OF BUSINESS OR INDUSTRY Private Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) None		17. INFORMANT & ADDRESS Family records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Coronary artery occlusion						INTERVAL BETWEEN ONSET AND DEATH 15 MIN.	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from MAR 18, 1956, to MAR 18, 1956, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:35 P.M. from the causes and on the date stated above.							
SIGNATURE Thaddaea C. Swinicki		ADDRESS (Street, city, town, state) M.D. 17 W. Poma Ave Towson		DATE SIGNED 3/19/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 20, 1956		NAME OF CEMETERY OR CREMATORY Pleasant Rest Cemetery		LOCATION (City, town, or county) (State) Towson, Maryland	
24. REC'D BY REGISTRAR DATE Mar. 20, 1956		REGISTRAR'S SIGNATURE Mabel C. Gray		25. FUNERAL DIRECTOR'S SIGNATURE John Burns' Son		ADDRESS Towson, Maryland	

31

10

Item 2, FilrG1 L 3-16-56 et

2595

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: <u>6811 Campfield Rd - 7</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore Co</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN		TOWN <u>Baltimore 18</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Augsburg Home</u>		STREET ADDRESS (If rural give location) <u>2752 Fenwick Avenue</u>	
3. NAME OF DECEASED: (First) <u>Catherine</u> (Middle) <u>Kal</u> (Last) <u>thof</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>March 8 1956</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>April 19-1867</u>
9. AGE last birthday: <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Decen</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	<u>Cerebral Hemorrhage</u>	<u>8 months</u>
ANTECEDENT CAUSE (B)	<u>Hypertensive Cardiovascular Disease</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C) <u>Generalized Arterio-sclerosis</u>	<u>5 yrs.</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>None</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

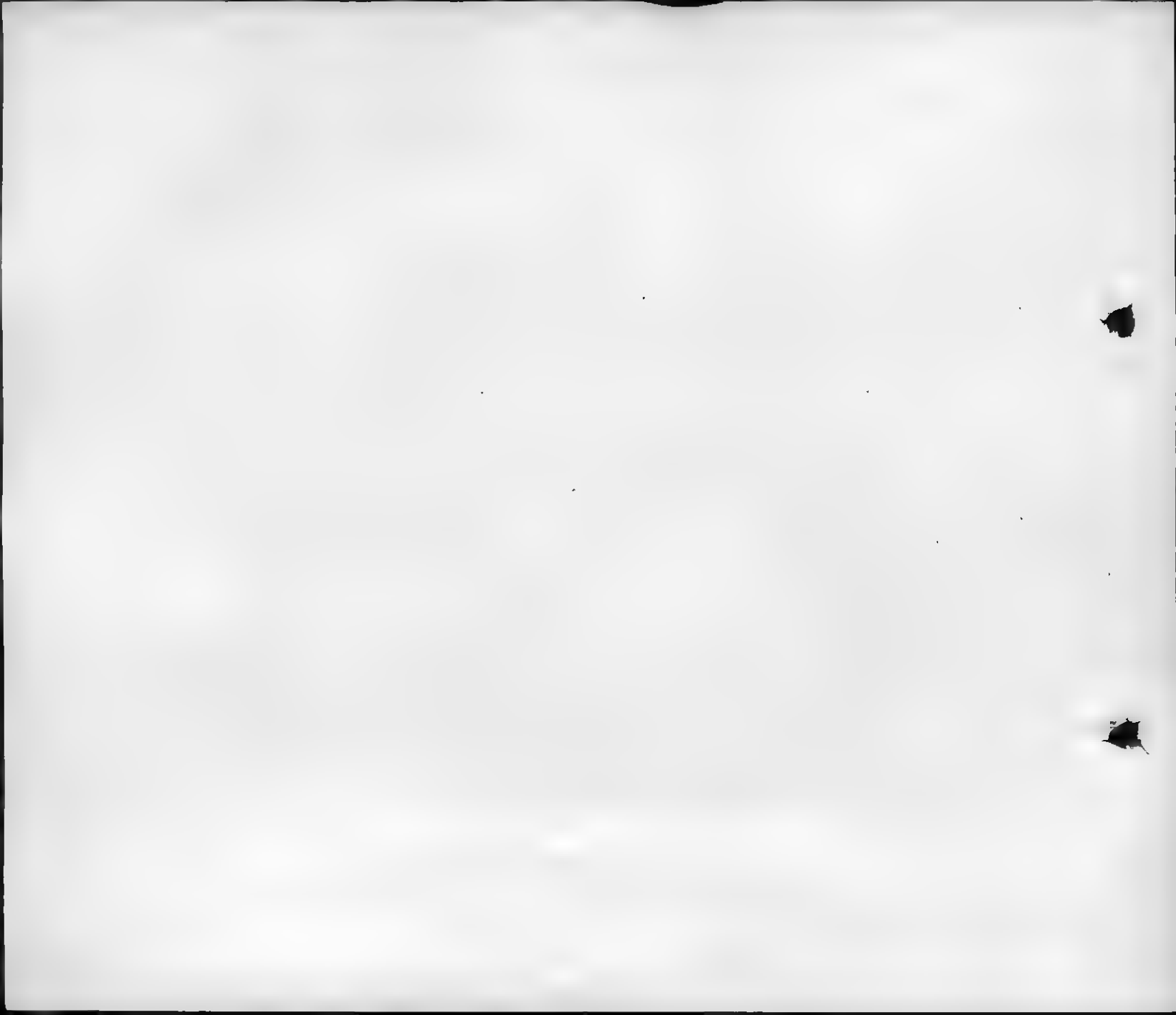
22. I hereby certify that I attended the deceased from May, 1955, to March 8th, 1956, that I last saw the deceased alive on March 1, 1956, and that death occurred at 9:15 M, from the causes and on the date stated above.

SIGNATURE Paul L. Chambers ADDRESS M.D. 4108 Liberty Hts Balt - 7 DATE SIGNED 3-9-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>3/10/56</u>	NAME OF CEMETERY OR CREMATORY <u>Emanuel Cemetery</u>	LOCATION (City, town, or county) <u>London Ave</u>
DATE REC'D BY LOCAL REGISTRAR <u>3-9-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>PAUL A. HEEMANN</u>	ADDRESS <u>6021 Highland</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02582

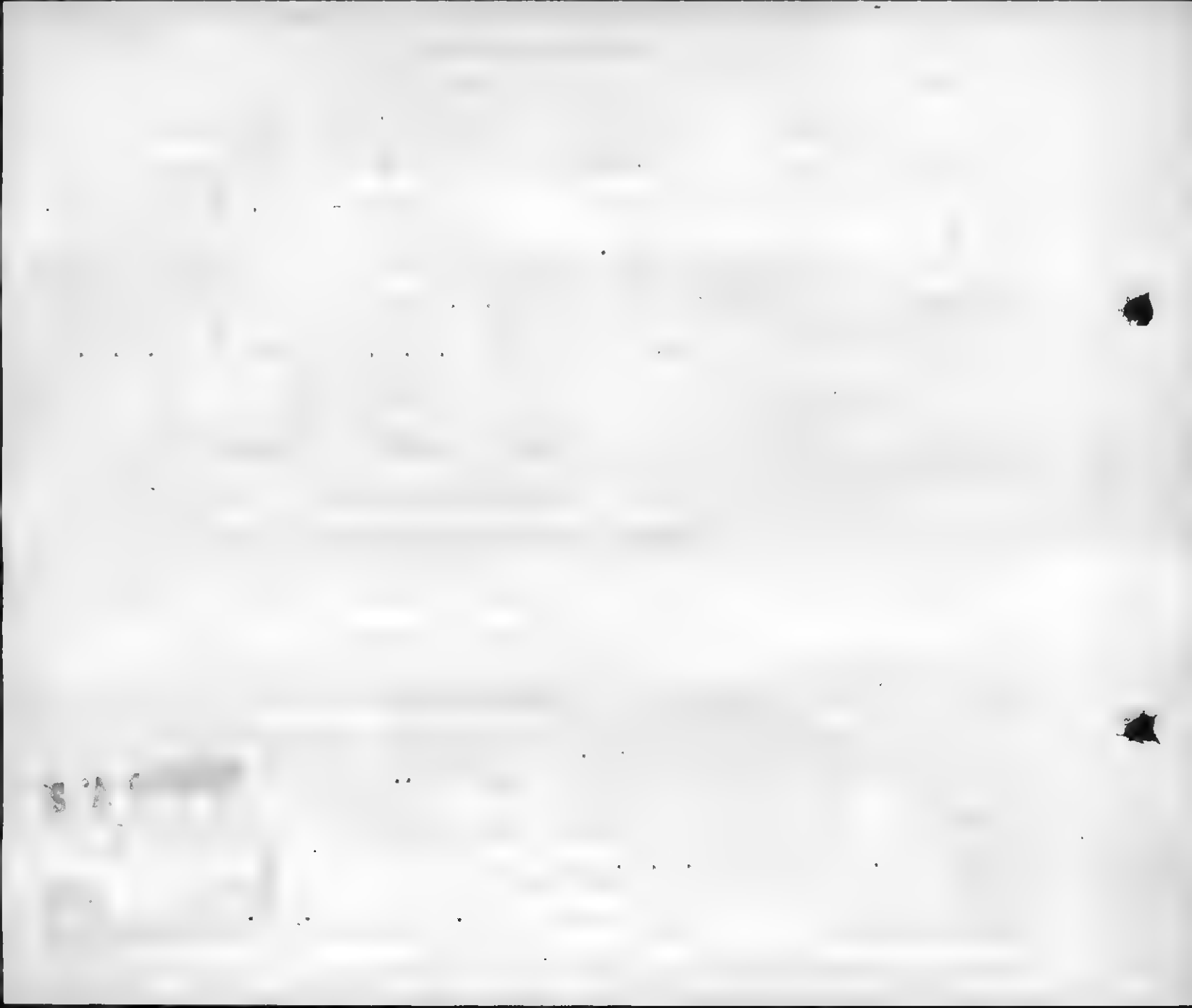
2596

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Balto. City b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2yrs. 4mths 13days Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 224 Hazel Avenue - Balto. 27			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ethel Middle C. Last Kastner				4. DATE OF DEATH Month March Day 14 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 9, 1894	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) U. S. A. - Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Albert Martin				14. MOTHER'S MAIDEN NAME Nellie Mahon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Balto.				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from Jan. 25, 1956 , to March 14, 1956 , that I last saw the deceased alive on March 14, 1956 , and that death occurred at 3:50 p.m. from the causes and on the date stated above ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 3-14-56 DATE SIGNED Catonsville 28, Maryland							
ACTUAL SIGNATURE T. Glyne Williams				M.D. SPRING GROVE STATE HOSPITAL 3-14-56			
PHYSICIAN'S NAME (Type) T. Glyne Williams, M. D.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.				24a. REC'D BY REGISTRAR DATE 1-1-56		24b. REGISTRAR'S SIGNATURE V. E. Harvey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, or FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2597

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mo 11days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle J. Last King		4. DATE OF DEATH Month March Day 17 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1876
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles King		14. MOTHER'S MAIDEN NAME (Winnie) Winifred Cloonan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Records; Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 hours years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6, 1956 to Mar. 17, 1956 that I last saw the deceased alive on Mar. 17, 1956 and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE T. Glyne Williams M.D.		ADDRESS (Street, city or town, state) Spring Grove State Hospital, Catonsville, Md.	
PHYSICIAN'S NAME (Type) T. Glyne Williams		DATE SIGNED 3/17/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/56	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickner & Sons - Balto		24a. REC'D BY REGISTRAR March 19, 1956 24b. REGISTRAR'S SIGNATURE T. E. Barry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 20 1956

11-11

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2598 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02584

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> 52	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6 Shipley Ave</u>		d. STREET ADDRESS <u>6 Shipley Ave</u>	
3. NAME OF DECEASED (Type or print) <u>George B King</u> First Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 17 67</u> 55 yrs.
10a. USUAL OCCUPATION (For kind of work done during most of working life, even if retired) <u>Laborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry King</u>		14. MOTHER'S MAIDEN NAME <u>Antonia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>6 Shipley Ave</u>	
17. INFORMANT <u>Dr. King</u> Address <u>6 Shipley Ave</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Cardiac Failure</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo M Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo M Kieffer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 9 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Weston Star</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold A Hensley</u> ADDRESS <u>578 W</u>		24a. REC'D BY REGISTRAR <u>DATE</u> 12 1956	
		24b. REGISTRAR'S SIGNATURE <u>V. E. Hays</u>	

RECEIVED

1968

1968

2599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 16	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>14 Spring Grove St. Hospital</u>		d. STREET ADDRESS <u>808 Whittemore Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type in full) First Middle Last <u>(Margaret) Marguerite E. KIRBY</u>		4. DATE OF DEATH Month Day Year <u>3 - 24 - 1956</u>	
5. SEX <u>f.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 29th 1893</u>
9. AGE (In years last birthday) <u>62 yrs</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August HAUCK</u>		14. MOTHER'S MAIDEN NAME <u>Catherine MEIER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Mr Rose NEAL</u>		Address <u>2518 V. Lafayette Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Multiple cerebral accidents</u> DUE TO (c) <u>Malignant Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-vascular accident 1951</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 16th</u> , 19 <u>50</u> , to <u>March 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-24</u> , 19 <u>56</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertrude J. Fleischman</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hospital</u>	
PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMAN</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>3/27/56</u>	<u>London PARK</u>	<u>BALTO Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Ruck</u>		ADDRESS <u>5305 Harford</u>	
24a. REC'D BY REGISTRAR <u>AR 2719</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Henry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES

WAR

RECEIVED

2522

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) OR
 TOWN Relay LENGTH OF STAY (in this place) 37 yrs
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 1731 Magnolia Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md COUNTY Baltimore
 CITY (If outside corporate limits, write RURAL and give nearest town) OR
 TOWN Relay
 STREET ADDRESS 1731 Magnolia Ave (If rural give location)

3. NAME OF DECEASED:

(First) Charles Lewis (Middle) Kroll (Last) Kroll

4. DATE (Month) (Day) (Year) OF DEATH: Mar 4 1956

5. SEX:

male

6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

widowed Feb 2-1924

8. DATE OF BIRTH:

82

9. AGE last birthday

82 yrs

IF UNDER 1 YEAR

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

German

10B. KIND OF BUSINESS OR INDUSTRY:

B & O R.R. Retired

11. BIRTHPLACE (State or foreign country):

Baltimore City

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

John W. Kroll

14. MOTHER'S MAIDEN NAME:

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

706-09-1597

17. INFORMANT & ADDRESS:

C. L. Kroll, (son) Relay 27 md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

Carcinoma of Prostate

ANTECEDENT CAUSE (S)

DUE TO

in carcinoma of prostate

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

Chor. Myocardium

DUE TO

in Vascularization

(C)

INTERVAL BETWEEN ONSET AND DEATH

5 yrs3 mo1 mo

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Sanclity57 mo

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1953, to Mar 4 1956, that I last saw the deceasedalive on Mar 3, 1956, and that death occurred at 4 a.m., from the causes and on the date stated above.

SIGNATURE

W. B. Drumblough

ADDRESS

M. D.

3609 Main St. 27 md 3/4/56

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

MAR. 7/56

NAME OF CEMETERY OR CREMATORY

MEADOWRIDGE

LOCATION (City, town, or county) (State)

DORSEY, M.D.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

W. B. Drumblough

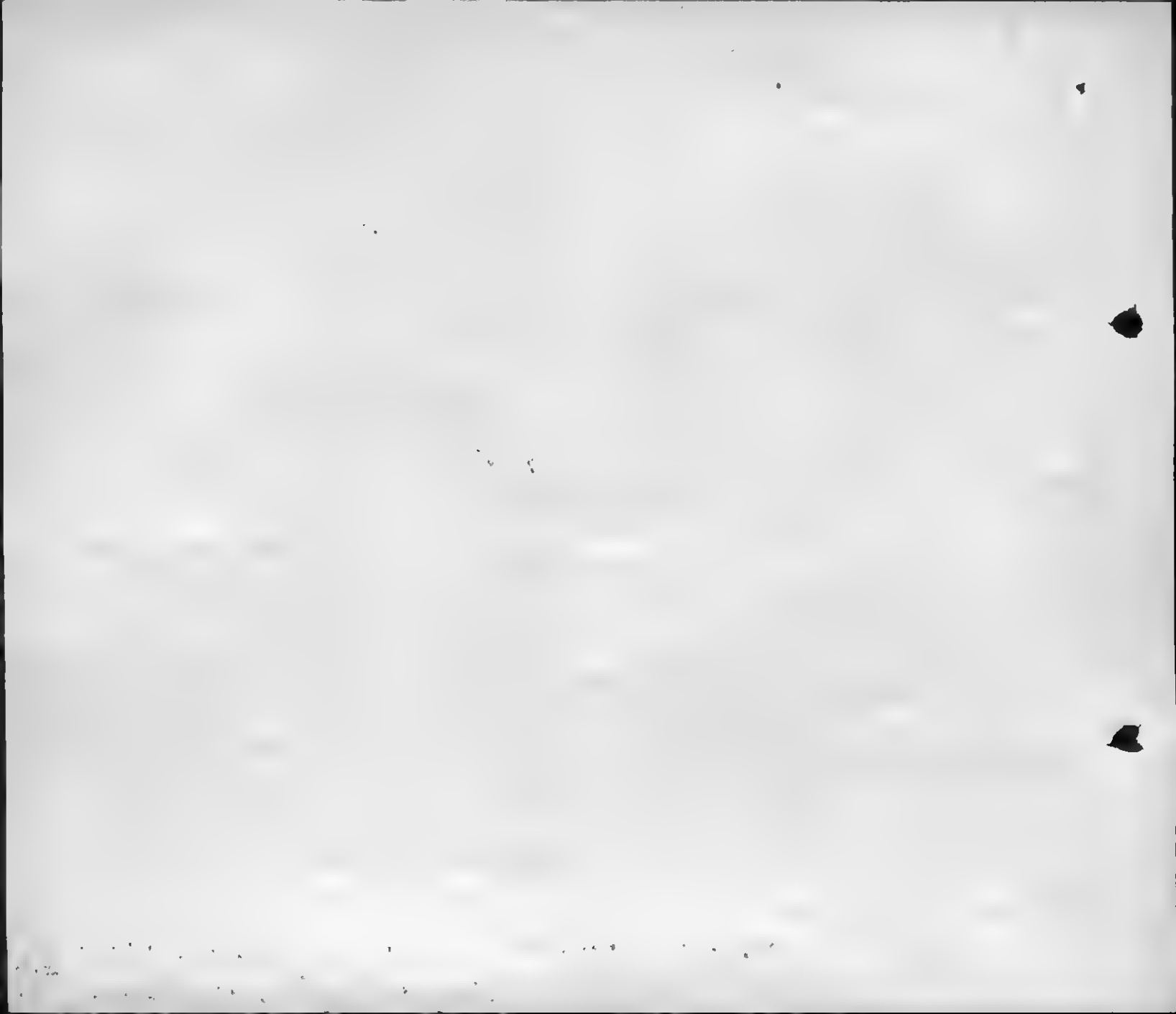
24. FUNERAL DIRECTOR

Harry H. Wible

ADDRESS

4101 EDMONDSON AVE

MARGIN RESERVED FOR BINDING



02587

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2690

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson Zone 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At Home</u>		STREET ADDRESS (If rural, give location) <u>910 Locustvale Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Katarzyna</u>	(Middle)	(Last) <u>Kulesza</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>22nd</u>	(Year) <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>12/1/1880</u>
9. AGE last birthday <u>75</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>ANTONI KALATA</u>		14. MOTHER'S MAIDEN NAME <u>ANNA SADOWSKI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>BERTHA HALLIDAY 910 LOCUSTVALE RD</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardiac thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) infectious

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

4 hrs4 hrs

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 15, 1956, to MAR 22, 1956, that I last saw the deceasedalive on MAR 15, 1956, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

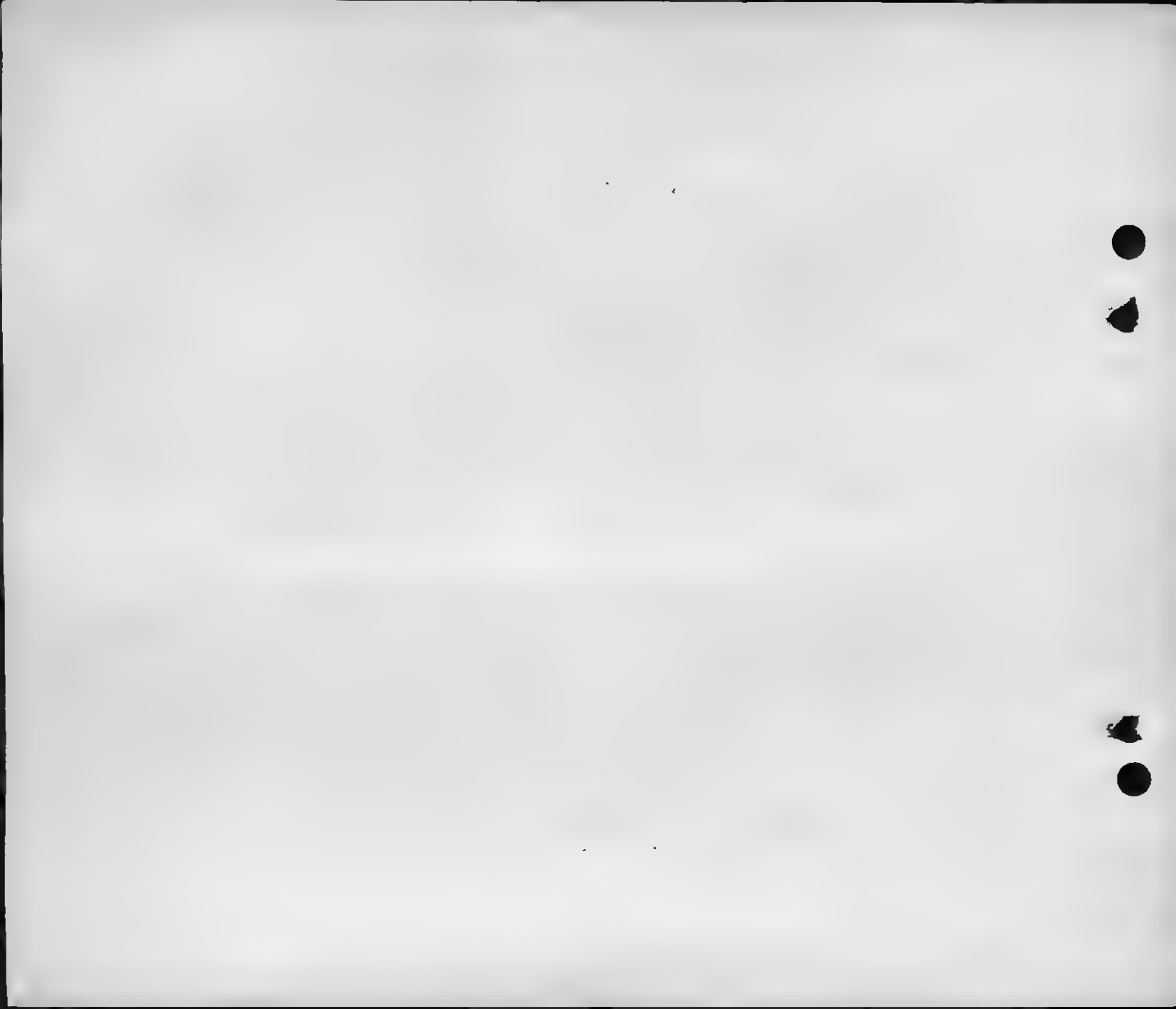
ADDRESS

March 24, 1956R.W.George A. Weber 705-S Green St

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2601 CERTIFICATE OF DEATH

02588

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Baltimore</u>		<u>1 yr</u>		TOWN <u>Catonsville + Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Nursing Home</u>				STREET ADDRESS (If rural give location) <u>329 Krumm Ave #1322 Krumm</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Catherine E</u> (Middle) <u>Kunz</u> (Last) <u>Kunz</u>				(Month) <u>March</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan 29, 1868</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Belgian Soda</u>		11. BIRTHPLACE (State or foreign country) <u>Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Walter Kunz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beneman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S ADDRESS <u>Mrs Pearl L. McKinney</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>		DUE TO				<u>3 weeks</u>	
ANTECEDENT CAUSE(S) (B) <u>14 pneumonia</u>		DUE TO				<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		DUE TO					
STATING UNDERLYING CAUSE LAST (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Bed Sores</u> <u>peripheral edema</u>						<u>3 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/9/56</u> to <u>3/7/56</u> , that I last saw the deceased alive on <u>2/29/56</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Carl Robert J.</u>		M.D. <u>4605 Edmondson ave</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>3/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 9, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Louder Ph</u>		LOCATION (City, town, or county) <u>Balto</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. H. W. Evans</u>		ADDRESS <u>1400 S. Charles</u>	
DATE <u>3-10-56</u>							

U. S. Navy

100

2602

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural				c. LENGTH OF STAY IN 1b 30 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Owings Mills			
				d. STREET ADDRESS Lyons Mill Road			
3. NAME OF DECEASED (Type or print) First Harry Middle Edward Last Lathe				4. DATE OF DEATH Month March Day 19 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1889		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher, retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Henery Lathe				14. MOTHER'S MAIDEN NAME Carrie Virginia Harvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-03-9181		17. INFORMANT Address Marie Sorg Brown, Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension & DUE TO arteriosclerosis (c)							INTERVAL BETWEEN ONSET AND DEATH 3-16-56 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month ✓ Day 19 Year 1956 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 3-19-56 to 3-19-56 , that I last saw the deceased alive on 3-19-56 , and that death occurred at 8 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Siffell				DATE SIGNED 3-20-56			
PHYSICIAN'S NAME (Type)				ADDRESS (Street, city or town, state)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Paran Cemetery		22d. LOCATION (City, town, or county) (State) Harrisonville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Smith				24a. REC'D BY REGISTRAR Mrs. Mary Elving		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17 17 17 17

17 17 17 17

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

2603 **CERTIFICATE OF DEATH**Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Md</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>1 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Relay Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in The Pines</u>		STREET ADDRESS (If rural give location) <u>5920 Southwestern Blvd</u>					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mary E. Lawrence</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 17 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/25/1882</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Relay Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Mr Wilfred A. Lawrence 5920 Southwestern Blvd</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
445X IMMEDIATE CAUSE (A) <u>Hypertensive A. S. C. I. S.</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Hemorrhage</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/2</u>, 19<u>53</u>, to <u>3/17</u>, 19<u>56</u>, that I last saw the deceased alive on <u>3/16</u>, 19<u>56</u>, and that death occurred at <u>11:07</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John C. Neely M.D.</u> M.D.				ADDRESS (Street, city, town, or county) <u>Hateley 27, Md</u>		DATE SIGNED <u>3/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Balto, National Cem.</u>		LOCATION (City, town, or county) (State) <u>5301 Frederick Ave</u>	
24. REC'D BY REGISTRAR <u>March 19, 1956</u>		REGISTRAR'S SIGNATURE <u>V.E. Larys</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Loran & Son</u>		ADDRESS <u>906 St.</u>	

RECEIVED
MAR 19 1944
U.S. DEPT. OF AGRICULTURE

2604

CERTIFICATE OF DEATH

02591

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION York Rd.		d. STREET ADDRESS York Rd.	
3. NAME OF DECEASED (Type or print) First Bertie Middle May Last Lloyd		4. DATE OF DEATH Month 3 Day 27 Year 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1870
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months 8 Days 5	IF UNDER 24 HRS Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Brown	
14. MOTHER'S MAIDEN NAME Rebecca Myers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT John A. Lloyd, Sparks, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction - chronic - degenerative DUE TO Valvular pneumonia - bronchial 4 weeks DUE TO Hypertension + arteriosclerosis 3 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-1930 to 3-28-56 , that I last saw the deceased alive on 3-26-56 , and that death occurred at 11:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James L. Saffell M.D.		DATE SIGNED 3-28-56	
PHYSICIAN'S NAME (Type) James L. Saffell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-30-56	22c. NAME OF CEMETERY OR CREMATORY Falls Rd. Chapel	22d. LOCATION (City, town, or county) (State) Sparks, Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks		24a. REC'D BY REGISTRAR DATE 30 March 56	24b. REGISTRAR'S SIGNATURE Gene Armieland MacNeil

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02592

2605

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 Garden Ridge Rd.</u>				STREET ADDRESS (If rural give location) <u>201 Garden Ridge Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles P. Lupton</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 25, 1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 9, 1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Lupton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hartman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Raymond B. Lupton, 201 Garden Ridge H</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Acute Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardio-vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 13, 1953</u> to <u>March 25, 1956</u> , that I last saw the deceased alive on <u>March 25, 1956</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George A. Furr</u>				ADDRESS (Street, city, town, state) <u>4116 Edmondson Avenue</u> DATE SIGNED <u>Mar. 27, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 29/56</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>T. E. Harvey</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witte</u>		ADDRESS <u>4101 Edmondson Ave</u>	

2606 CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CATONSVILLE</u>		<u>1 month</u>		TOWN <u>Spanners Point</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St. Hosp.</u>				STREET ADDRESS (If rural give location) <u>2614 Massett Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>John E. LYDIC</u>				<u>3 / 3 / 1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Mar.</u>		8. DATE OF BIRTH: <u>12-25-1879</u>	
9. AGE last birthday: <u>76</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Penn.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		12. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>—</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>			
13. FATHER'S NAME: <u>Jacob Lydic</u>				14. MOTHER'S MAIDEN NAME: <u>Wardline Bouch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO: <u>—</u>			
17. INFORMANT & ADDRESS: <u>Hospital record</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
3.22 X IMMEDIATE CAUSE (A) <u>Uremia</u>							
ANTECEDENT CAUSE (B) <u>Cerebral Thrombosis (Right)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Generalized Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION.				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <u>2 / 2</u> , 1956, to <u>3 / 3</u> , 1956, that I last saw the deceased alive on <u>3 / 3</u> , 1952, and that death occurred at <u>11:10</u> P M, from the causes and on the date stated above.							
SIGNATURE <u>J. E. Lydic</u>				ADDRESS <u>—</u>		DATE SIGNED <u>3/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>REMOVAL</u>		<u>MAR 4, 1956</u>		<u>TAYLORSVILLE CEM</u>		<u>HILLSDALE PA</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1956-11-14</u>		<u>—</u>		<u>MULLERICH FUNERAL HOME</u>		<u>212 DUNDALK</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2607

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1 yr 1 mo. 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roderick Middle Hanson Last MacKenzie				4. DATE OF DEATH Month March Day 19 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-15-1908	
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navigation Specialist				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME William Allen MacKenzie				14. MOTHER'S MAIDEN NAME Hulda A. Hanson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records Spring Grove State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pyonephrosis 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonism due to Hypertensive CVA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb. 15, 1955 to March 19, 1956 , that I last saw the deceased alive on March 19, 1956 , and that death occurred at 10:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital, Catonsville, Md. DATE SIGNED 3-19-56 ACTUAL SIGNATURE Louise Frances Woodward PHYSICIAN'S NAME (Type) Louise Frances Woodward							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF March 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Jasshi's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE 3/23/56	
24b. REGISTRAR'S SIGNATURE Wm. H. Hargis							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MINERAL V. S.

MAR 1900

RECEIVED
MAR 1900

CERTIFICATE OF DEATH

2678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 mo. 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Simon Middle Marget Last 1883		4. DATE OF DEATH Month March Day 23 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883
9. AGE (in years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Massachusetts
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records Spring Grove State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensatory Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Myocardial Degeneration DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-29 , 19 56 , to 3-23 , 19 56 , that I last saw the deceased alive on 3-23 , 19 56 , and that death occurred at 11:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Isadore Tuerk, M.D.		ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 3-23-56	
PHYSICIAN'S NAME (Type) Isadore Tuerk, M.D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar 25/56	22c. NAME OF CEMETERY OR CREMATORY Mickro Kodesh, Herring Run	22d. LOCATION (City, town, or county) (State) Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC 1124-26 W. North Ave		24a. REC'D BY REGISTRAR DATE 3-27-1956	
24b. REGISTRAR'S SIGNATURE T. E. Harry			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

MAR

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2609

CERTIFICATE OF DEATH

02596

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Res. dence before admission) b. STATE Maryland b. COUNTY BALTC.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (21)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 38 Glenwood Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ROBERT Middle A. Last MARKLE				4. DATE OF DEATH Month March Day 24 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/09	9. AGE (In years last birthday) 46 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Research Technician U.S. Government				10b. KIND OF BUSINESS OR INDUSTRY North Fork, California		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander R. Markle				14. MOTHER'S MAIDEN NAME Rutha Mae Patton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 218-18-1409			
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LEUKEMIA 204.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 16, 1955 , to March 24, 1956 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald D. Mark M.D.				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND			
DATE SIGNED 3/24/56							
PHYSICIAN'S NAME (Type) DONALD D. MARK, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Althea Burke Bradley				ADDRESS Lincoln, Md		24a. REC'D BY REGISTRAR DATE 7 1956	
24b. REGISTRAR'S SIGNATURE Dawson L. Lasker							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. V. S.

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1911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2610

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

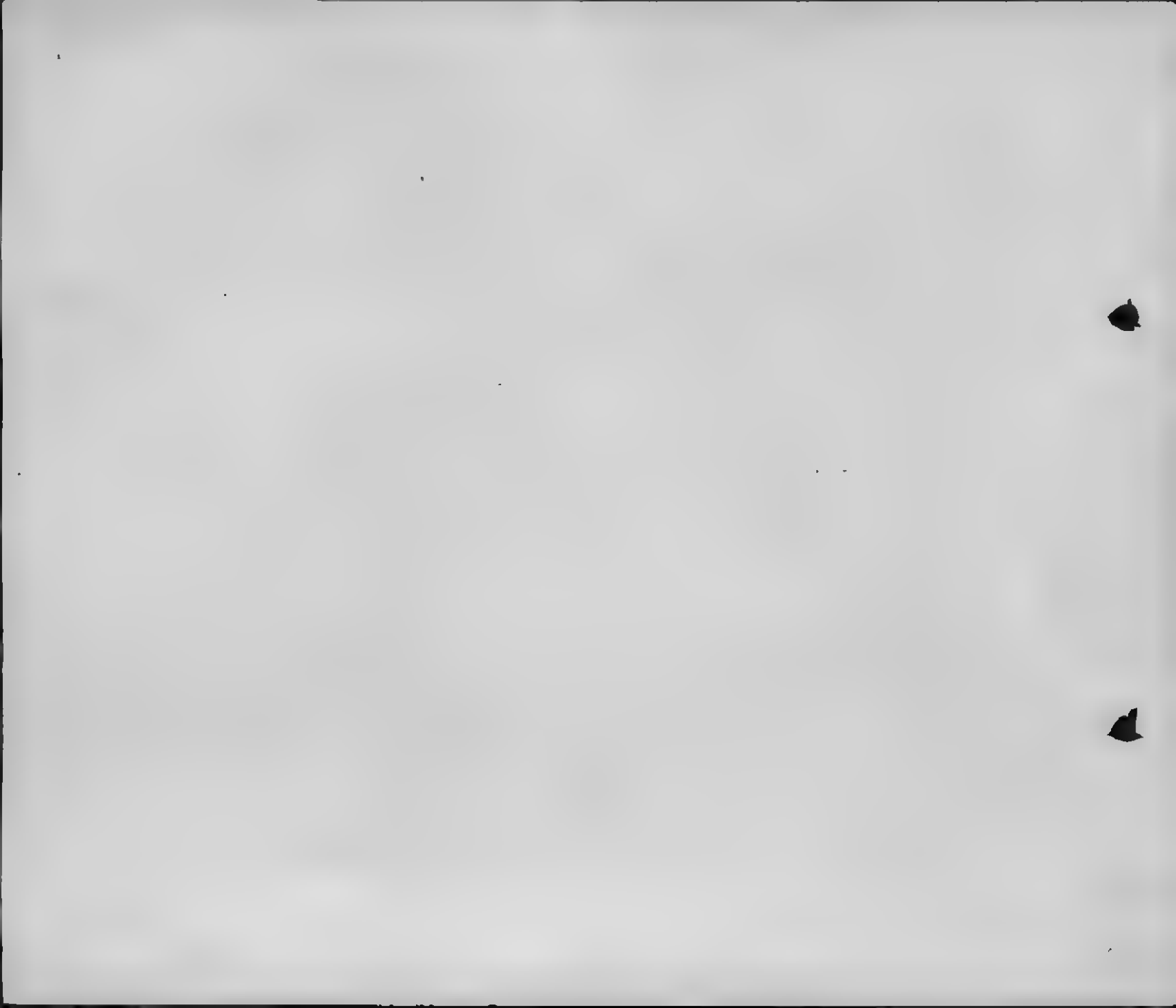
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02597

Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockdale</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rockdale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3623 Langrehr Rd.</u>				STREET ADDRESS (If rural, give location) <u>3623 Langrehr Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>BERNARD C. MARTIN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 18 19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>May 5, 1918</u>	9. AGE last birthday: <u>37</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Industrial Eng.-Radiator Mfg.</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Ohio</u>	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Bernard Cheston Goldberg</u>				14. MOTHER'S MAIDEN NAME: <u>Nettie S. Conwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>W.W.#2</u>			16. SOCIAL SECURITY No.: <u>218-05-0451</u>		17. INFORMANT & ADDRESS: <u>Rockdale, Md.</u> <u>Mrs. Stefania Martin-3623 Langrehr Rd.</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							5 min. . .
Immediate cause (a) <u>Coronary Occlusion</u>							
DUE TO							
Antecedent cause(s) (b)							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION: <u>none</u>			19b. MAJOR FINDING OF OPERATION: <u>none</u>			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>none</u>		21c. (City or town) (County) (State) <u>none</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>E.D. Caples</u>		M. D.		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>		DATE SIGNED <u>3-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-21-56</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>Wm. J. Tibbels & Sons Balto.</u>		24. FUNERAL DIRECTOR <u>12, Md.</u>		ADDRESS	



Item 10 Film 614

2611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Bethlehem Steel Co. Dispensary</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Co. Dispensary</u>			d. STREET ADDRESS <u>218 Shadynook Ct.</u>		
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas E. Martin</u>			4. DATE OF DEATH Month Day Year <u>3-15-56</u> 19		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <u>12-12-1938</u>		9. AGE (In years last birthday) <u>17</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oiler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Thomas B. Martin</u>			14. MOTHER'S MAIDEN NAME <u>Virginia E. Wilcox</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>213-36-4730</u>		
17. INFORMANT <u>Thomas B. Martin</u>			Address <u>218 Shadynook Ct. (28)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crushing injury to chest.</u> <u>712.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>NONE</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Caught between body & frame of crane</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u>3-15</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off ca. bldg., etc.) <u>Steel Plant</u>	
20f. (City or town) <u>Sparrows Point</u>		20g. (County) <u>Balto</u>		20h. (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>M. B. Davis</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>M. B. Davis, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	
22d. LOCATION (City, town, or county) <u>Woodlawn,</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Howard Strong</u>			ADDRESS <u>3207 W. North Ave.</u>		
24a. REC'D BY REGISTRAR DATE <u>3-15-56</u>			24b. REGISTRAR'S SIGNATURE <u>Dawson L. Fisher</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

34

0657 0700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institutions; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randalltown</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mass & off Mt Rd</u>		e. STREET ADDRESS <u>Mass & off Mt Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Selma Anna Martign</u>		4. DATE OF DEATH <u>Med 4</u> 19 <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20 1878</u>
9. AGE (In years last birthday) <u>77 yrs</u>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Austrian</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert H Martign</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth M. Martign</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Herbert H Martign</u>	
17. INFORMANT <u>Herbert H Martign</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac failure</u> DUE TO (b) <u>cardiovascular</u> DUE TO (c) <u>disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dr. M. Kieffer</u>		DATE SIGNED <u>Med 5 56</u>	
EXAMINER'S NAME (Type) <u>Dr. M. Kieffer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Med 6 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Northview Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Randalltown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>		24a. REC'D BY REGISTRAR <u>Dr. M. Kieffer</u>	
ADDRESS <u>Parkville</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. M. Kieffer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WILLIAM K. S.

MAR

1953

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

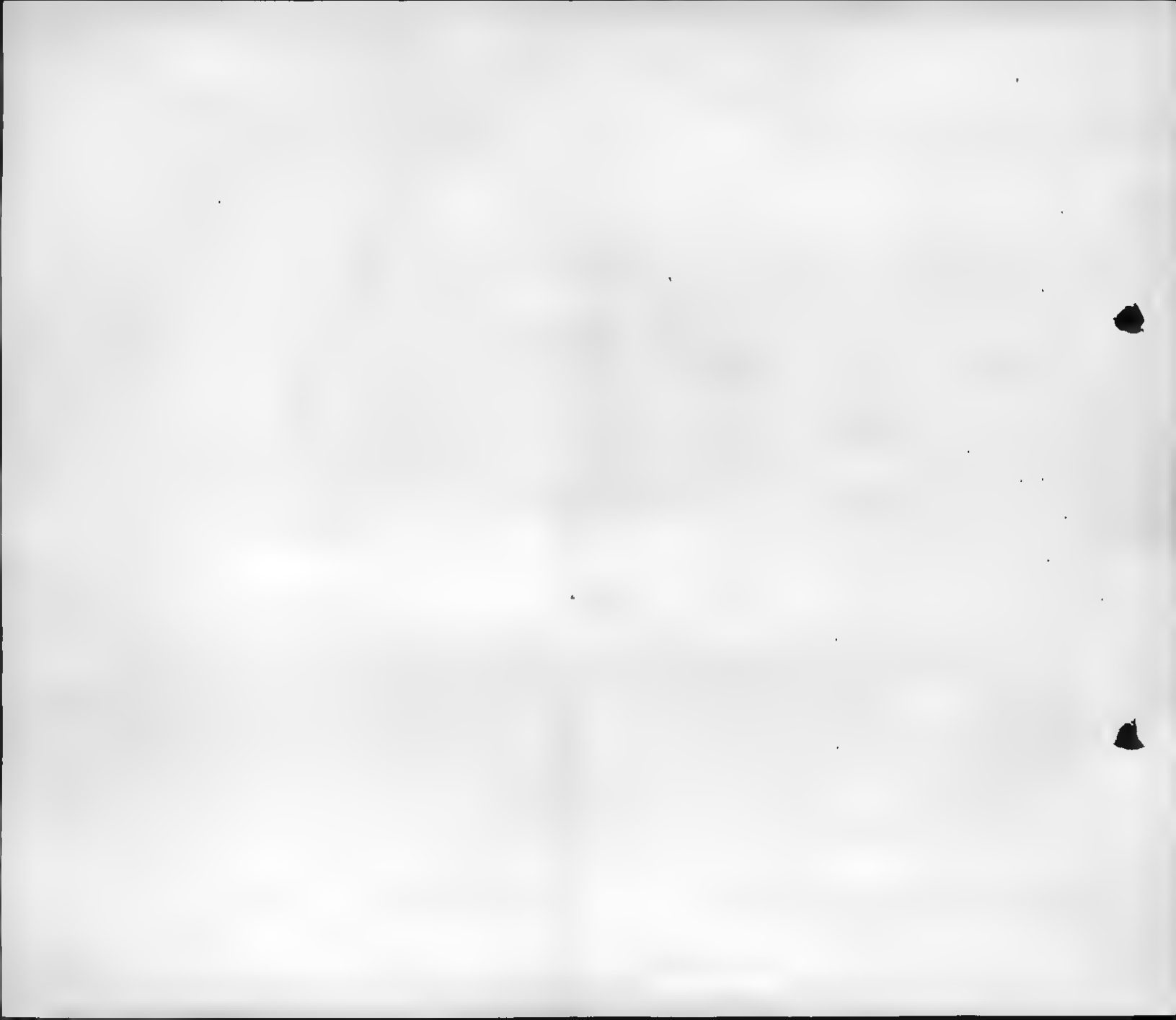
02600

2613

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY _____	
CITY (If outside corporate limits, write RURAL) _____		CITY (If outside corporate limits, write RURAL and give nearest town) _____	
OR TOWN <u>Gettysburg</u>		OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>2417 Dulaney Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Sahina Agnes McCormack</u>		<u>March 2, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>9-23-1887</u>
9. AGE last birthday <u>66</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Ireland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Thomas Ward</u>		14. MOTHER'S MAIDEN NAME: <u>Mary McDERMOTT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Arteriosclerosis, generalized</u>			
(B) ANTECEDENT CAUSE (S) <u>Dehydration</u>			
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Senility</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7- , 1953, to 3-2- , 1956, that I last saw the deceased alive on 3-2- , 1956, and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
SIGNATURE <u>Sheila Wachler</u>		DATE SIGNED <u>3-2-56</u>	
23. BURIAL, CREMATION REMOVAL, (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-5-56</u>	
NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		LOCATION (City or town, or county) <u>BALTIMORE Md.</u>	
REGISTRAR'S SIGNATURE <u>GW</u>		24. FUNERAL DIRECTOR <u>George L. Schwal</u>	
DATE PEC'D BY LOCAL REGISTRAR <u>March 3, 1956</u>		ADDRESS <u>Baltimore Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

02601

2411 N. Charles Street, Baltimore

2014

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> TOWN <u>Woodlawn</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6822 Dogwood Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> TOWN <u>Woodlawn</u> STREET ADDRESS (If rural, give location) <u>6822 Dogwood Road</u>	
3. NAME OF DECEASED (First) <u>Emma H.</u> (Middle) <u>Meekins</u> (Last) <u></u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>11</u> (Year) <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 12, 1894</u>
9. AGE last birthday <u>61</u> yrs. If under 1 year Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		10. BIRTHPLACE (State or foreign country) <u>Balto. md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Franck</u>		14. MOTHER'S MAIDEN NAME <u>Margrethe Stump</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>Mr. Albert J. Meekins - 6822 Dogwood Rd. 7</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>Coronary Thrombosis</u>		<u>36 hours</u>
(b) <u>Arteriosclerotic Cardio-Vascular Disease</u>		<u>4 years</u>
(c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>no operation</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 16, 1949, to Mar. 11, 1956, that I last saw the deceased alive on Mar. 11, 1956, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE <u>Joshua H. Ammacost M.D.</u>		ADDRESS <u>6419 Windsor Mill Rd Baltimore 7 Md.</u>		DATE SIGNED <u>3-12-56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/14/56</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
LOCATION (City, town, or county) <u>Balto.</u>		(State) <u>md.</u>			
DATE REC'D BY LOCAL REG. <u></u>		REGISTRAR'S SIGNATURE <u></u>		24. FUNERAL DIRECTOR <u>John T. Stansbury</u>	
				ADDRESS <u>6411 Windsor Mill Rd. 7</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.



3-1-21 12-1-21

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

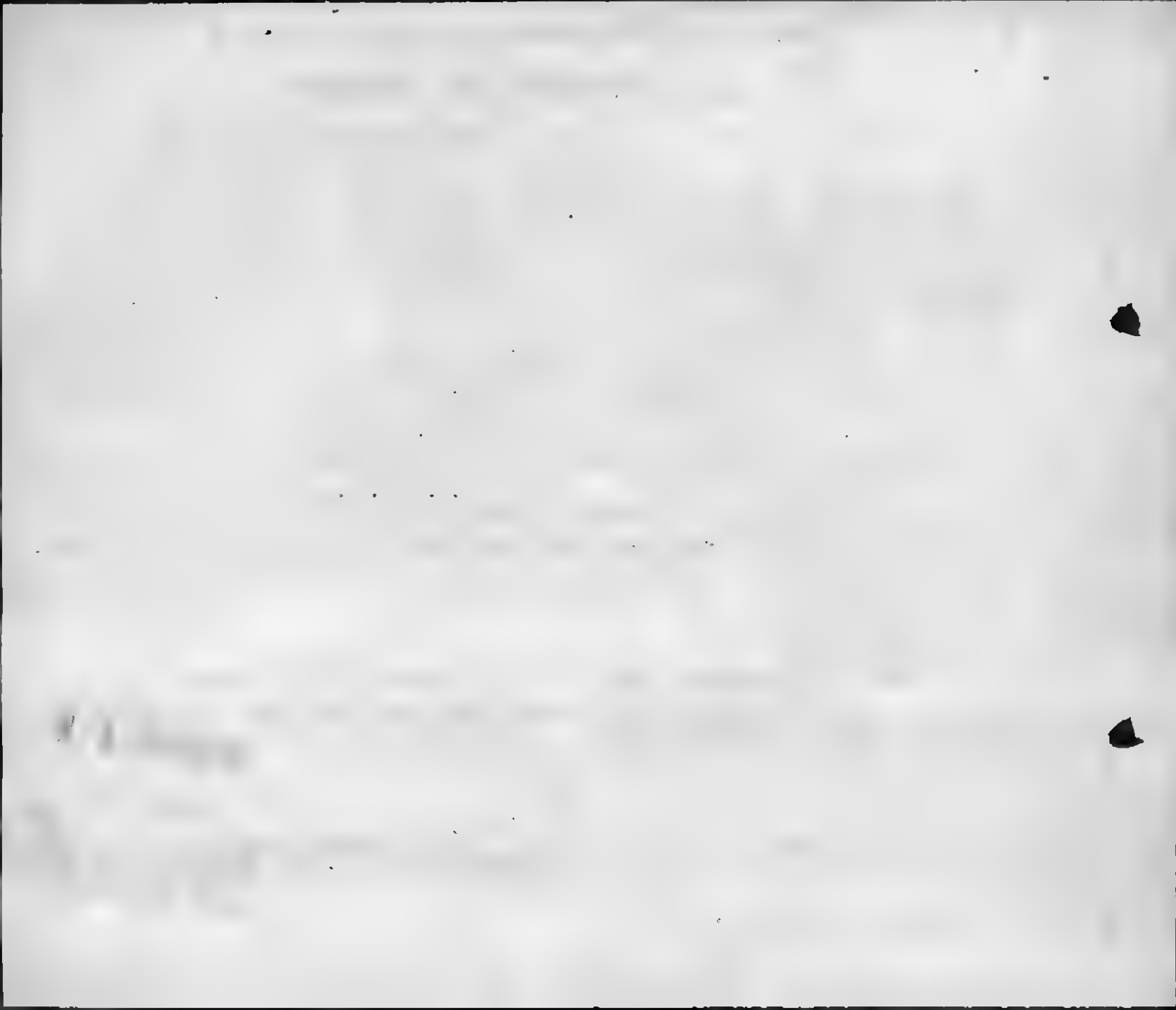
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2616 CERTIFICATE OF DEATH

02603

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWN Towson</u>		LENGTH OF STAY (If this place) <u>6 mon.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>420 York Road</u>				STREET ADDRESS (If rural give location) <u>420 York Road</u>			
3. NAME OF DECEASED (Type or Print) <u>EMILIJA</u> (First) <u>MEZGALS</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>16</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>May 29, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u> (DP)	
13. FATHER'S NAME <u>Christoph Privert</u>				14. MOTHER'S MAIDEN NAME <u>Louisa ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>U.S. Govt. D.P. Papers</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Hypertensive cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Diabetes mellitus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/9/1954</u> to <u>3/16/1956</u> that I last saw the deceased alive on <u>3/11/1956</u> and that death occurred at <u>3:20</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Paul H. Amundson</u>				ADDRESS (Street, city, town, state) <u>M.D. 3800 Erdman Ave, #13</u>		DATE SIGNED <u>3/16/1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mehl Grays</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons</u>		ADDRESS <u>Towson, Maryland</u>	
DATE							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02604

2617

CERTIFICATE OF DEATH

Reg. Dist. No.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR INK PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information supplied by physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER THE DEATH.

1. NAME OF DECEASED (Type or Print) FATHER'S CLARENCE MILES			2. DATE OF DEATH 3/24/56		
3. PLACE OF DEATH: A. Baltimore City, Maryland Catonsville Md.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Caton Ridge Nursing Home			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) IN					
c. Length of stay in Baltimore					
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 9-27-1867		9. AGE (In years last birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Sparks Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Buck Miles			14. MOTHER'S MAIDEN NAME Marion Marks		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 2-1-1-344	17. INFORMANT ADDRESS Mrs. E. C. Burings 6027 Bellvue Ave		
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) As static pneumonia			INTERVAL BETWEEN ONSET AND DEATH 5 days		
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. As static pneumonia 6 Bed Sore			6 months		
III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Aged					
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I, OR PART II (Day) (Year) (Hour)		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21A. TIME OF INJURY		21B. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Feb 23 19 56 to March 23 19 56 , that (I) (we) last saw the deceased alive on March 23 19 56 , and that death occurred at 12:30 p.m. from the causes and on the date stated above.					
23A. SIGNATURE Jeff Carter		23B. ADDRESS 4605 Edmondson Ave		23C. DATE SIGNED 3/28/56	
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE March 31, 1956	24C. NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE RECEIVED BY LOCAL REGISTRAR 3/29/56		REGISTRAR'S SIGNATURE W. W. Beckwith		25. FUNERAL DIRECTOR ADDRESS Everworth Remacrest	



2618

CERTIFICATE OF DEATH

Reg. Dist. No. 37

Items 11, 12 File C195 4-6-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Ba</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lutherville, Md.</u>				TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor Nursing Home</u>				STREET ADDRESS (If rural give location) <u>4 Chancery Square</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>HENRIETTA STEVENS MILLS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 26, 1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 9, 1880</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>unknown Stevens</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Hurlock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Rowland V. Mills-4 Chancery Square</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hrt. Sclerosis - Cerebral softening</u>				<u>years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Old Hemiplegia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Obesity - Hypertension</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma - Colon?</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1/4/55</u> to <u>Mar 26 1956</u> , that I last saw the deceased alive on <u>Mar 25, 1956</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter A. Baetjer</u>		M.D. <u>1001 5th Ave SE</u>		ADDRESS (Street, city, town, state) <u>Bethesda</u>		DATE SIGNED <u>2nd</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/29/56</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		LOCATION (City, town, or county) <u>Pikesville, Md.</u>	
24. REC'D BY REGISTRAR <u>Gene MacRae</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tidener & Sons - Balt</u>		ADDRESS	

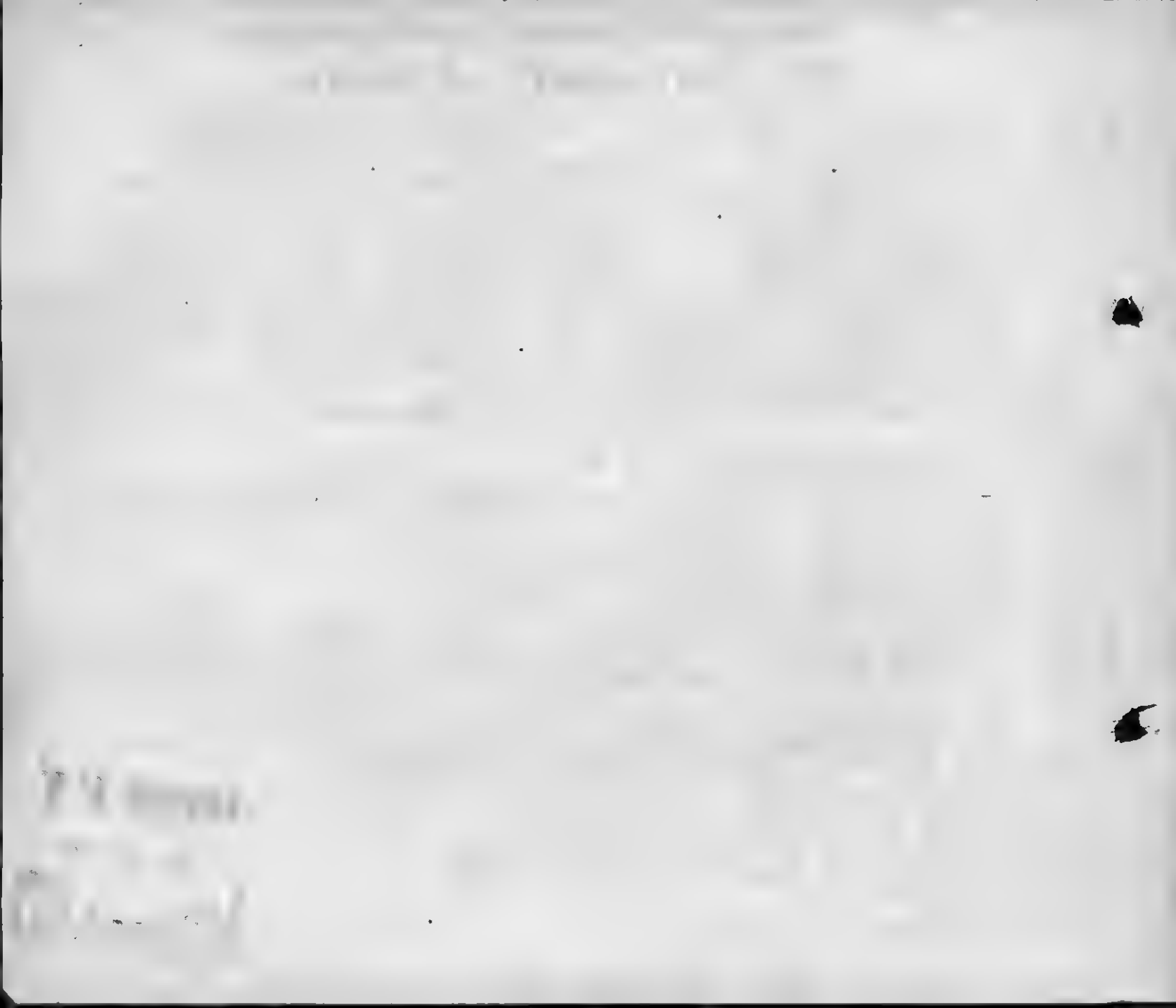
INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



Reg. Dist. No.

MEDICAL CERTIFICATION



2620 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kidewood</u>		LENGTH OF STAY (in this place) —		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kidewood</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1725 W. Joppa Road</u>				STREET ADDRESS (If rural give location) <u>1723 W Joppa Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Lina</u> (Middle) <u>H.</u> (Last) <u>Morris</u>				(Month) <u>Mar</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>—</u>	8. DATE OF BIRTH <u>Apr 11-1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Fredericks Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Ephraim B Morris</u>				14. MOTHER'S MAIDEN NAME <u>Susan C. Prim</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Whitette Box 1725 W Joppa Rd</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Haemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/6/1956</u> , to <u>3/7/1956</u> , that I last saw the deceased alive on <u>3/7/1956</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. H. Quinn</u> M.D.				DATE SIGNED <u>3/8/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar 10 1956</u>		NAME OF CEMETERY OR CREMATORY <u>MT Zion</u>		LOCATION (City, town, or county) <u>Fredericks Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns</u>		ADDRESS <u>Box 4</u>	
DATE <u>March 9, 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

U. S. DEPARTMENT OF AGRICULTURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must be filled in by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and coroner, the certificate must be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2621

CERTIFICATE OF DEATH

02608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
c. LENGTH OF STAY IN 1b <u>9 yrs</u>		3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mercy Villa</u>		d. STREET ADDRESS <u>1523 W. Pratt St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>A.</u> Last <u>Murphy</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>26</u> Year <u>19 56</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Margaret</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Miss Patricia Murphy, 1523 W. Pratt St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 4, 1956</u> to <u>March 26, 1956</u> , that I last saw the deceased alive on <u>3/25</u> 19 <u>56</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P.D. Flynn</u> M.D.		ADDRESS (Street, city or town, state) <u>11 E. Chase St Baltimore, Md</u>	
DATE SIGNED <u>3/27/56</u>			
PHYSICIAN'S NAME (Type) <u>P.D. Flynn</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Balto. Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. White</u> ADDRESS <u>4101 EDWINSON AVE</u>		24a. REC'D BY REGISTRAR DATE <u>3/28/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mark Gray</u>			

RECEIVED 7. S.

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VS. AISME(S)
5M 9/55

U. S. S. 100-100

2623 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>290 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>Route #2 Box 128-A</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLES</u> (First) <u>MYERS</u> (Middle) (Last)				4. DATE OF DEATH <u>March 1</u> 19 <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>February 2, 1882</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier- Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Louisville, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Myers</u>				14. MOTHER'S MAIDEN NAME <u>Alice Devine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW I</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS WITH LEFT HEMIPLEGIA</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED ARTERIOSCLEROSIS</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
18 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>VA</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> attended the deceased from <u>May 16, 1955</u> , to <u>March 1, 1956</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>F. G. Dickey</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>3/2/56</u>			
F. G. DICKEY, M.D., Chief Medical Service		VAH, FORT HOWARD, MARYLAND					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Mar 5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fort Myer, Virginia</u>	
24. RECD BY REGISTRAR <u>March 7, 1956</u>		REGISTRAR'S SIGNATURE <u>L. L. Larkins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md</u>	
DATE							

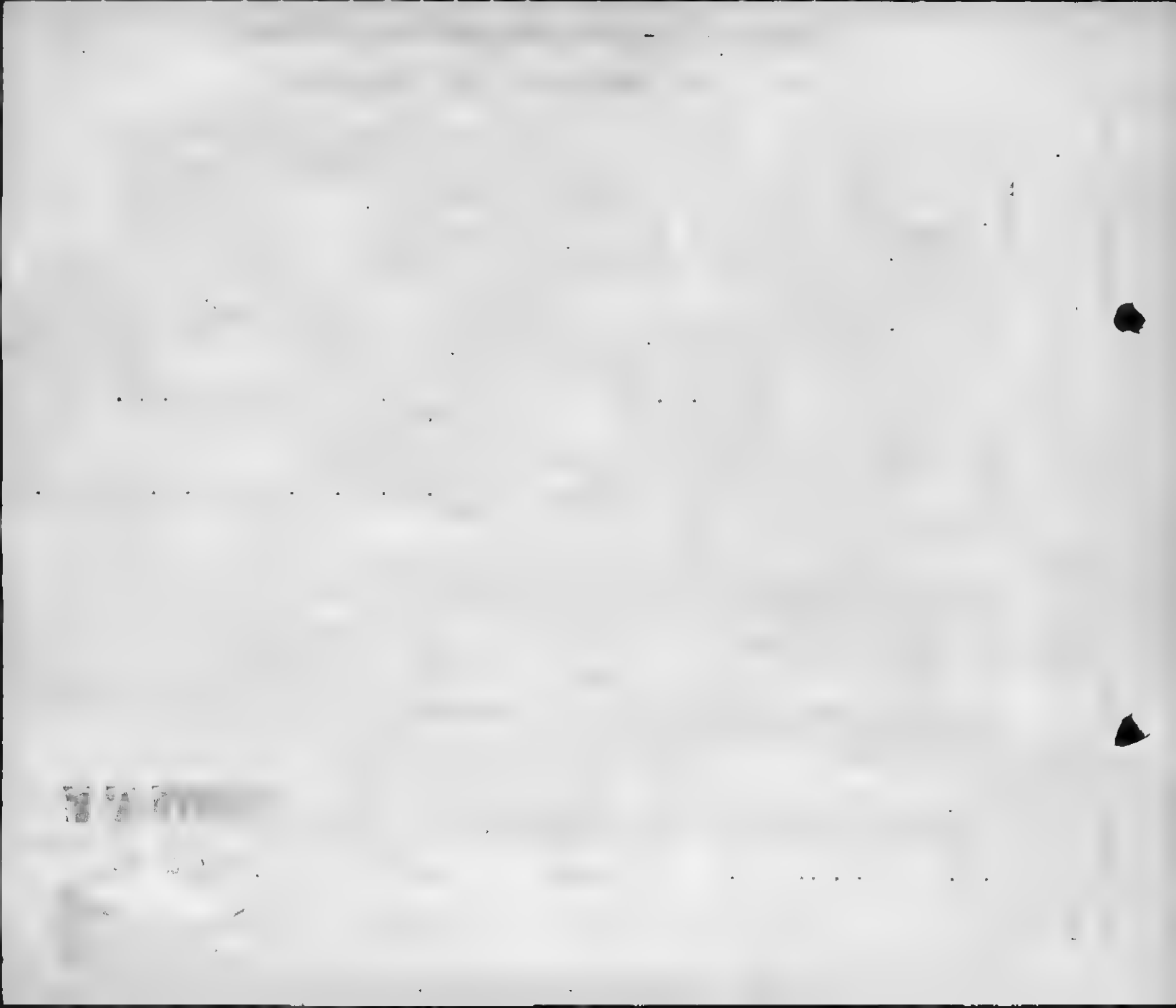
R. V. Singleton, Funeral Home, Glen Burnie, Maryland

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02611

2516

CERTIFICATE OF DEATH

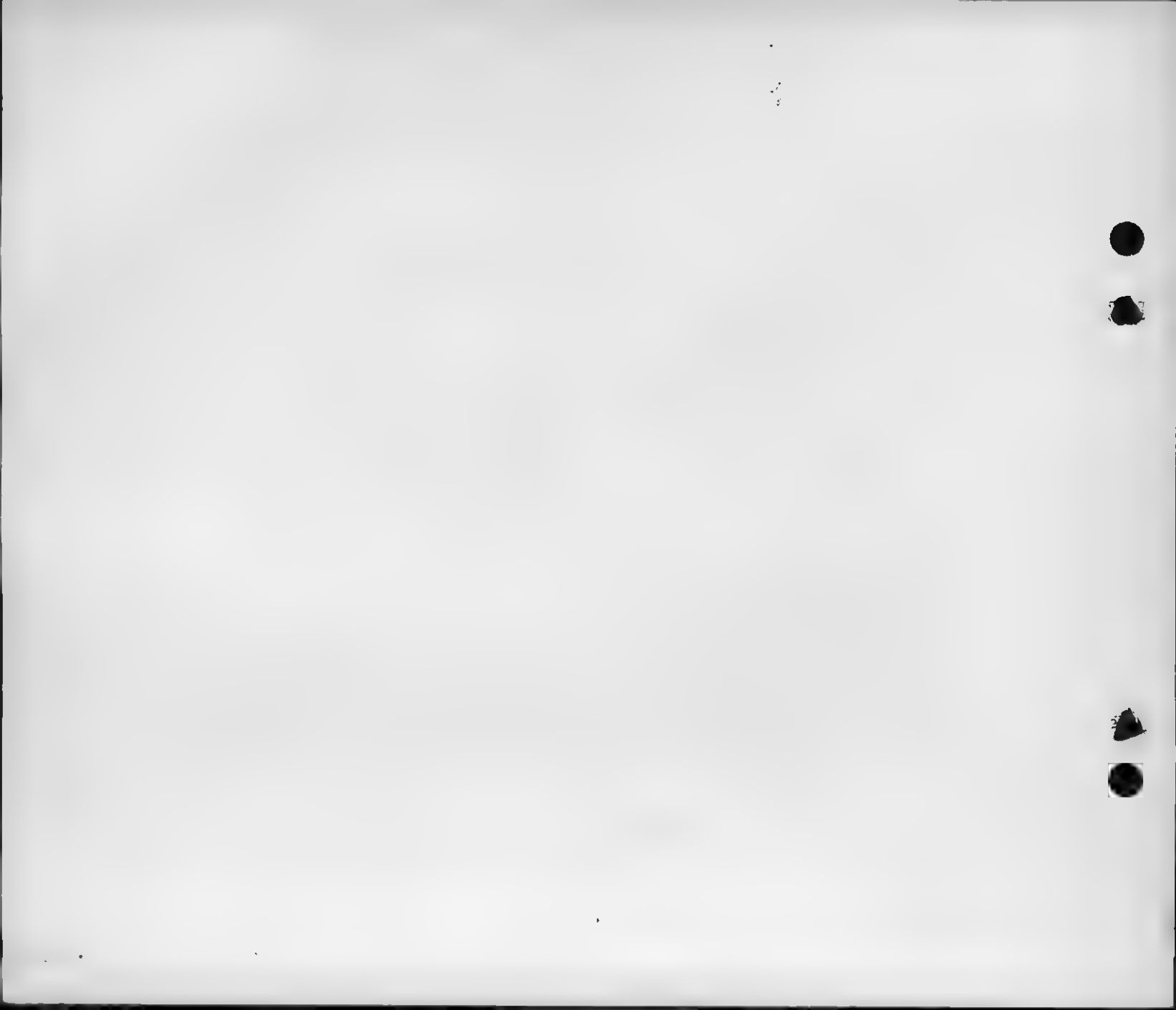
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>undale 22</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>300 SOLLERS POINT ROAD</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>undale 22</u> TOWN STREET ADDRESS (If rural, give location) <u>300 SOLLERS POINT ROAD</u>	
3. NAME OF DECEASED (Type or Print) <u>ANN</u> <u>CATHERINE</u> <u>Neal</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>18</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>September 12, 1871</u>
9. AGE last birthday <u>84</u> yrs. <u>6</u> Months <u>6</u> Days <u>16</u> Hours <u>30</u> Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <u>Charles County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Wreer</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Sarah Neal Williams 300 Sollers Point Rd.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Immediate cause</u> <u>Uremia</u>		<u>4 days</u>	
(b) <u>Antecedent cause(s)</u> <u>Broncho - Pneumonia</u>		<u>7 days</u>	
(c) <u>Hepatitis</u>		<u>3 wks</u>	
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u> <u>INJURY</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 18, 1956</u>		INJURY OCCURRED While at <u>Work</u> <input type="checkbox"/> Not While <u>At work</u> <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 3, 1950</u> , to <u>March 18, 1956</u> , that I last saw the deceased alive on <u>March 18, 1956</u> , and that death occurred at <u>3:25 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>William E. Glade M.D.</u>		ADDRESS <u>1400 W. Avenue undale 22 Maryland</u>	
DATE SIGNED <u>March 18, 1956</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>3/21/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles R. Law</u>		ADDRESS <u>802-04 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A15



2624

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Balto.,			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradshaw				c. LENGTH OF STAY IN 1b 40 yrs.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle H. Last Mason				4. DATE OF DEATH Month March Day 11 Year 1956			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 3, 1878	9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Scott Nason				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Henry Mason Address Joppa, Harford Co., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 352x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stasis - paralysis DUE TO (c) Cerebral hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 5 days 7 days 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from March 7, 1956 , to March 11, 1956 , that I last saw the deceased alive on March 9, 1956 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Tyson M.D.				ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 3-11-56			
PHYSICIAN'S NAME (Type) William A. Tyson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 14, 1956		22c. NAME OF CEMETERY OR CREMATORY Asbury		22d. LOCATION (City, town, or county) (State) Loreley, Balto., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son				ADDRESS Abingdon, Maryland.		24a. REC'D BY REGISTRAR DATE 3-14-56	
				24b. REGISTRAR'S SIGNATURE Wm X Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 10 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2625 CERTIFICATE OF DEATH

02612

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MD. b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle F. Last NEUS				4. DATE OF DEATH Month 3 Day 24 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-1889		9. AGE (in years last birthday) 66 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ADAM (JOHN) NEUS, Jr.				14. MOTHER'S MAIDEN NAME LOUISE WOLFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Hosp. Rec'd. & Paul Neus - nephew Address City - 18			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) with pulmonary congestion - terminal						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) pneumonitis, Rt. Lower lung							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-23-1956 , to 3-24-1956 , that I last saw the deceased alive on 3-24-1956 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David E. Edwards M.D.				ADDRESS (Street, city or town, state) Spring Grove Hosp., Catonsville, Md. DATE SIGNED 3-24-56			
PHYSICIAN'S NAME (Type) DAVID E. EDWARDS M.D.				Spring Grove Hosp.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Stuart H. Mowen ADDRESS 108 W. North Ave. Balto - 1 Md.				24a. REC'D BY REGISTRAR APR 27 1956		24b. REGISTRAR'S SIGNATURE V. E. Harry	

U. S. A. OVER

2626 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 28yrs. 1mth.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle F. Last Osterman		4. DATE OF DEATH Month March Day 15 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-17-1892 unknown
9. AGE (In years last birthday) 62 1/2 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chauffer		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adam Osterman unknown		14. MOTHER'S MAIDEN NAME BARBARA BOHL unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records of Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.0 (c) 11			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 3, 1956 to March 15, 1956 that I last saw the deceased alive on March 15, 1956 and that death occurred at 10:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE T. Glyne Williams Clinical Director		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
PHYSICIAN'S NAME (Type) T. Glyne Williams, M.D.		DATE SIGNED 3-16-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-17-1956	
22c. NAME OF CEMETERY OR CREMATORY LODGE PARK		22d. LOCATION (City, town, or county) (State) BALTIMORE md	
23. FUNERAL DIRECTOR'S SIGNATURE Glenn F. Setz		24a. REC'D BY REGISTRAR March 19, 1956	
ADDRESS 5209 York Rd		24b. REGISTRAR'S SIGNATURE F.E. Harvey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and cemetery are to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1956

RECEIVED

02614

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2627 CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. NAME OF DECEASED
(Type or Print)

Mrs. Anna E. Payson

2. DATE
OF
DEATH

Mar 10, 1956

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore County*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

6129 Marglen Avenue

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

4221 Berger Avenue #6

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Oct. 2, 1896

9. AGE (In years
last birthday)

59

If Under 1 Year

If Under 24 Hours

Months Days

Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Strunge

14. MOTHER'S MAIDEN NAME

Magdalene Beelat

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. William Payson, 4221 Berger Avenue

18. *170X*DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Metastasis

DUE TO

ANTECEDENT CAUSES

(B)

Carcinoma right breast

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN
ONSET AND DEATH*2**1*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR

22. I certify that (I) (this hospital) attended the deceased from... *March 1956*... to... *March 1956*... that (I) (we) last saw the deceased alive on... *March 1956*... and that death occurred at... *March 1956*... m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

Mar. 14, 1956

24C. NAME OF CEMETERY OR CREMATORY

Moreland Memorial Park

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road #14

MAR 13 1956

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

3 2 5 -

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03760
2628 CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. NAME OF DECEASED (Type or Print) Dora Peterson			2. DATE OF DEATH March 11, 1956		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1249 Primrose Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and name town) Baltimore Md.		
C. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 1249 Primrose Ave.		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 27, 1899		9. AGE (in year last birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITY AND STATE OF WHAT COUNTRY?
13. FATHER'S NAME Adam Schmitt			14. MOTHER'S MAIDEN NAME Agnes Schmitt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 18	17. INFORMANT ADDRESS Elizabeth Rapold 1249 Primrose Ave.		
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion					5 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic heart disease					14 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus					2 yrs.
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from August 27, 1953, to March 11, 1956, that I last saw the deceased alive on February 15, 1956, and that death occurred at 6:30 p.m., from the causes and on the date stated above.					
23A. SIGNATURE M. J.		23B. ADDRESS 8019 Ashford Rd.		23C. DATE SIGNED 3-12-56	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-14-56		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25. FUNERAL DIRECTOR ADDRESS B. Dabrowski 2818 E. Baltimore St.			
DATE RECEIVED BY LOCAL REGISTRAR MAR 13 1956		REGISTRAR'S SIGNATURE Dr. J. J. Rapold			

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. correct age is especially int. Physicians: please write the causes of death clearly and legibly.

y. The

THOMAS V. S.

APR 2

1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and can only be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

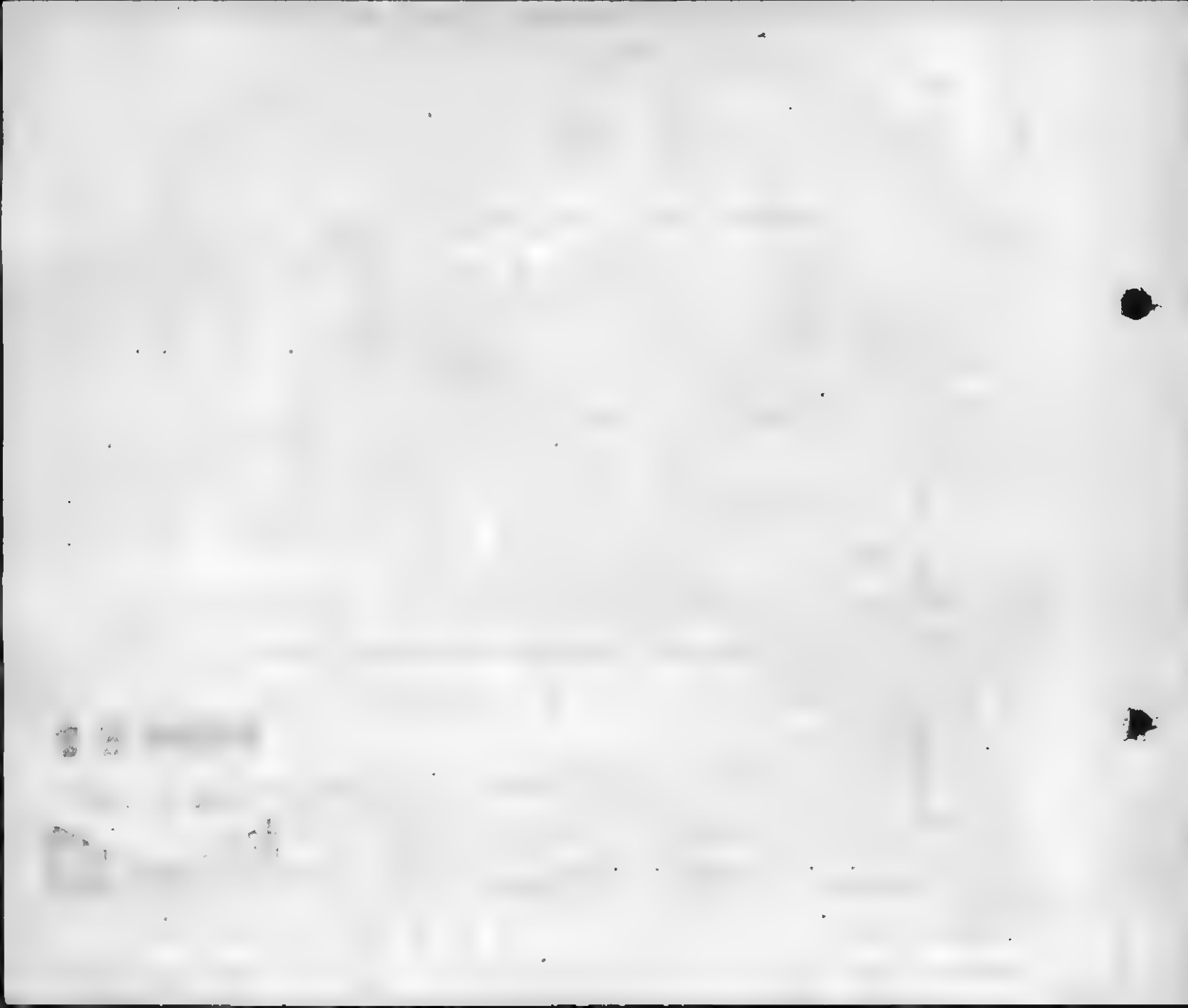
2629

CERTIFICATE OF DEATH

Reg. Dist. No.

02615

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b 83 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 639 Main				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
				d. STREET ADDRESS 639 Main			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hannah Middle May Last Pfeffer				4. DATE OF DEATH Month March Day 15 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1872	
				9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Reisterstown, Md.	
13. FATHER'S NAME William A. Russell				14. MOTHER'S MAIDEN NAME Abbie Ann Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None		17. INFORMANT K. Russell Pfeffer, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 410 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Rheumatic Arteriosclerotic DUE TO C-V Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH 30 min. 11 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 3-8-45 , 19____, to 3-15-56 , 19____, that I last saw the deceased alive on 2-22-56 , 19____, and that death occurred at 11:30 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd., Reisterstown, Md. DATE SIGNED 3-19-56							
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd., Reisterstown, Md.					
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Luthern		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 3-19-56		24b. REGISTRAR'S SIGNATURE D. D. Eline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02616

2630

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resurrection State Dr. School</u>		d. STREET ADDRESS <u>1010 Boyd</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>PIERSON</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-06</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patient at Rosewood</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Howard Pierson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Farrell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address <u>Rosewood Owings Mills, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardia failure; Cor Pulmonale</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002X</u> (b) <u>Ehrlich's Disease, sclerotic, hypertensive</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 1</u> , 19 <u>56</u> to <u>Mar 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 24</u> , 19 <u>56</u> , and that death occurred at <u>4:10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wesley B. Johns</u>		DATE SIGNED <u>3/24/56</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
M.D. <u>Resurrection State Dr. Sch</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar 29-56</u>	<u>Rosewood</u>	<u>Owings Mills Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elmer, Sons Rustertown Md</u>		24a. REC'D BY REGISTRAR DATE <u>3-29-56</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Wesley B. Johns</u>	

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. S.

2631

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> · 19 · MARYLAND		STATE <u>MD</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR and give nearest town		LENGTH OF STAY (in this place)		OR TOWN <u>M</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2514 Sycamore Ave</u>		STREET ADDRESS <u># 1</u>		(If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>JOHN. POPE</u>				<u>Mar 4 19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Dec 24. 1905</u>	9. AGE last birthday: <u>50</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Hauling</u>		11. BIRTHPLACE (State or foreign country): <u>Suffolk. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wesley Pope</u>				14. MOTHER'S M maiden NAME: <u>Helia Edwards</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>217-34-9038</u>		17. INFORMANT & ADDRESS: <u>James Pope 2818 Lodge Farm Rd Balto 19.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Acute myocardial Failure -</u>		DUE TO		<u>Sudden</u>	
Antecedent cause(s) (b) <u>Chronic myocarditis.</u>		DUE TO		<u>2 yrs.</u>	
(c) <u>Chronic bronchial asthma.</u>				<u>14 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from..... 19 <u>42</u> to <u>MAR 4, 1956</u> , that I last saw the deceased alive on <u>MAR 1, 1956</u> , and that death occurred at <u>12 45 P</u> m., from the causes and on the date stated above.					
SIGNATURE <u>James N. Tollin. M.D.</u>		(DEGREE OR TITLE) ADDRESS <u>6908 N. P+ Rd. Balto. 19. Md.</u>		DATE SIGNED <u>Mar. 4. 1956</u>	
23. REMOVAL, CREMATION OR BURIAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-7-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Calvary Cmo</u>	
LOCATION (City, town, or county) (State) <u>A. A. Co Md</u>		24. FUNERAL DIRECTOR <u>Rayner Sanders</u>		ADDRESS <u>217 E Preston St</u>	
DATE REC'D BY LOCAL REG. <u>3/7/56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02618

2632

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn			
c. LENGTH OF STAY IN 1b 8 Mos.				d. STREET ADDRESS 2005 Thayer Terrace			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2005 Thayer Terrace				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Adele Middle G. Last Potter				4. DATE OF DEATH Month March Day 9 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-10-1873	
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 9 Days 9 Hours 19 Min.		11. IF UNDER 24 HRS. Months 9 Days 9 Hours 19 Min.		12. IF UNDER 24 HRS. Months 9 Days 9 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife				10b. KIND OF BUSINESS OR INDUSTRY --			
11. BIRTHPLACE (State or foreign country) Md				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Montimer Dorsey				14. MOTHER'S MAIDEN NAME Sally B. Crapster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. P.H. Boyer 2005 Thayer Terrace (7)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute dilatation of heart DUE TO cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH about 20 min. P	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Feb.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 28 , 19 56 , to March 9 , 19 56 , that I last saw the deceased alive on March 9 , 19 56 , and that death occurred at 7:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas. S. Niblett				ADDRESS (Street, city or town, state) 2220 Harrison Blvd DATE SIGNED March 10/56			
PHYSICIAN'S NAME (Type) Walter S. Niblett							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong				ADDRESS 3207 W. North Ave		24a. REC'D BY REGISTRAR DATE 3/15/56	
				24b. REGISTRAR'S SIGNATURE Mr. Wm. C. Martin			

MEDICAL CERTIFICATION

9.

2633

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>1704 Ruxton Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>(NMI)</u> Last <u>PRATT</u>		4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1890</u>
9. AGE (In years last birthday) <u>65 33/4</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>	
11. BIRTHPLACE (State or foreign country) <u>West River, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Alec Pratt</u>		14. MOTHER'S MAIDEN NAME <u>Winnie Peters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT <u>Clinical Records, Vet. Adm. Hosp. Ft. Howard, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UNKNOWN</u> DUE TO (c) <u>UNKNOWN</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 16, 1955</u> to <u>March 28, 1956</u> and that death occurred at <u>12:00PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald D. Mark</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3/29/56</u>	
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>		VAL. <u>FORT HOWARD, MD</u> <u>3/29/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/31/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Lox</u>		24a. REC'D BY REGISTRAR <u>3/31/56</u>	
ADDRESS <u>802 Madison Ave. Balto. 7, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Walter L. Parker</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR

1950

2634

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md.	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Randallstown		OR TOWN Randallstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		9001 Liberty Road	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
Mary Frances Rainey		3-10-56 19	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED: Widowed	8. DATE OF BIRTH: Aug 10, 1868
9. AGE last birthday: 87 yrs		10. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home		10B. KIND OF BUSINESS OR INDUSTRY: Ireland	
11. BIRTHPLACE (State or foreign country): U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Unknown		14. MOTHER'S MAIDEN NAME: Lena McSweeney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: John Patrick Rainey 9001 Liberty Road			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE	(A) DUE TO	4 days	
ANTECEDENT CAUSE (S)	(B) DUE TO	10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	(C) DUE TO	12 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 1, 1956 , to March 10, 1956 , that I last saw the deceased alive on March 10, 1956 , and that death occurred at 6:45 M. from the causes and on the date stated above.			
SIGNATURE [Signature]		ADDRESS 3001 Liberty Rd - Baltimore DATE SIGNED 3/10/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF March 13, 56	NAME OF CEMETERY OR CREMATORY New Cathedral	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REGISTRAR 3-12-56	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Ellsworth Armbrust ADDRESS 4600 Liberty Heights Ave.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2523

CERTIFICATE OF DEATH

02621
47

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. LENGTH OF STAY IN 1b 17 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 612 Gun Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Louise Last Read		4. DATE OF DEATH Month March Day 26 , Year 1956	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 6, 1863
9 AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward P. Shannon		14. MOTHER'S MAIDEN NAME Amanda Hutchinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Viola Sonnenberg		Address 612 Gun Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Arteriosclerosis Generalized DUE TO (c) Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 days Undet. Undet.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 17, 1954 , to March 26, 1956 , that I last saw the deceased alive on March 25, 1956 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1764 Francis Ave, Baltimore Md DATE SIGNED 3-26-56 ACTUAL SIGNATURE A. Bradley Daugharthy M.D. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-28-1956	22c. NAME OF CEMETERY OR CREMATORY Baltimore	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong		24. REG'D BY REGISTRAR APR 8 DATE	24b. REGISTRAR'S SIGNATURE J. Leo M. Kipper

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. The attending physician and the funeral director must sign the certificate. After the certificate is signed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3. 18 cm.

1102

MARYLAND STATE DEPARTMENT OF HEALTH

02622

2635

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH: COUNTY Baltimore, MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Towson		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Presbyterian Home		STREET ADDRESS (If rural, give location) 802 St. Paul St.	
3. NAME OF DECEASED (Type or Print)	(First) Helen (Middle) Ma (Last) Richardson	4. DATE OF DEATH (Month) March (Day) 1, (Year) 1956	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) single	8. DATE OF BIRTH Nov. 11, 1862
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 93 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Harford Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William L. Richardson		14. MOTHER'S MAIDEN NAME Ann Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mrs. Twilah Elliott Presbyterian Home			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Pulmonary edema, hypostatic (terminal)**

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Cardio-renal-vascular disease**(c) **Senile changes with arteriosclerosis**

INTERVAL BETWEEN ONSET AND DEATH

3 days**Unknown****Unknown**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June, 1951 , to March 29th, 1956 , that I last saw the deceased alive on Feb. 29, 1956 , and that death occurred at 6:30 A. M. , from the causes and on the date stated above.					
SIGNATURE Rollin C. Hudson M.D.		(Degree or title)		ADDRESS 606 Baltimore Ave. Towson, Md.	
DATE SIGNED March 1st 1956					
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF March 3, 1956		NAME OF CEMETERY OR CREMATORY Loudon Park	
LOCATION (City, town, or county) (State) Baltimore, Md.					
DATE REC'D BY LOCAL REG. March 3 1956		REGISTRAR'S SIGNATURE R.W.		24. FUNERAL DIRECTOR John O. Mitchell & Sons Inc. 1900 Eutaw Pl.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03772

2636

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN TB 17 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 243 State Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EDWARD First RIGGIN Middle LAST				4. DATE OF DEATH March Month 11 Day 1956 Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1893		9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter & Sander		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Seth Riffin				14. MOTHER'S MAIDEN NAME Mary Sterling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 218-14-2535		17. INFORMANT Address Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA INVOLVING LIVER AND LYMPH NODES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that VA attended the deceased from February 23, 1956 , to March 11, 1956 , and that death occurred at 5:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 3/12/56							
ACTUAL SIGNATURE Donald D. Mark M.D. VAH, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-56		22c. NAME OF CEMETERY OR CREMATORY American Legion Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshy Funeral Home, Crisfield, Maryland				24a. REC'D BY REGISTRAR DATE 3/13/56		24b. REGISTRAR'S SIGNATURE Dr. Lawson & Farber	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2637 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02623

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1month4days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Allendale 2501 Allendale Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle A. Last Riley				4. DATE OF DEATH Month March Day 7, Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 9-17-1882		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months _____ Days _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Unknown Alexander Abrams			
14. MOTHER'S MAIDEN NAME Unknown Ida McCoovray				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records Spring Grove State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Therapeutic misadventure due to electric shock therapy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Electric shock therapy					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10 3-7-19 56 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital			
20f. (City or town) Catonsville		(County) Balto.		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>George S. M. Kieffer</i>		EXAMINER'S NAME (Type) George S. M. Kieffer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 3-7-56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/56		22c. NAME OF CEMETERY OR CREMATORY Western Cem.			
22d. LOCATION (City, town, or county) Balto., Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Wm. J. Lickner & Sons - Balto 17 MD</i>				24. REGISTRAR'S SIGNATURE <i>Wm. J. Lickner</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



2638

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Colgate

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

508 Old North Point Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md

COUNTY

CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN

Colgate

STREET ADDRESS (If rural give location)

508 Old North Point Rd.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Elizabeth S Rippel

4. DATE OF DEATH:

(Month)

(Day)

(Year)

March 18 / 56

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

FWMarriedApril 20, 188669

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

At home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

George Bauer

14. MOTHER'S MAIDEN NAME:

Lena Frederick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No.

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

William Rippel 508 Old North Point Road

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

446X
Immediate cause(a) URem 19

DUE TO

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.(b) NephrosclerosisDUE TO Cervical Spondylosis

(c)

Interval Between Onset And Death

6 weeks2 years5 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 8, 1952, to March 18, 1956, that I last saw the deceasedalive on March 18, 1956, and that death occurred at 10:09 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Thomas C. Jones MD1010 North Point Rd3/19/56

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BurialMar. 21, 1956Oak Lawn CemeteryColgate, Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3-21-56 W. H. HedrickUllrich Funeral Home 2112 Dundalk Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certifying physician is especially important. Physicians: please write the causes of death clearly and legibly.



2639

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperoo (Rural)</u>				c. LENGTH OF STAY IN 1b <u>15 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ✓				d. STREET ADDRESS ✓			
3. NAME OF DECEASED (Type or print) <u>GEORGE - E - RUBY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27 - 1896</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cover</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harward Ruby</u>				14. MOTHER'S MAIDEN NAME <u>Rora Mas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs Geo E Ruby</u> Address <u>Upperoo Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma Pancreas</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>4 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 14, 1956</u> to <u>March 14, 1956</u> , that I last saw the deceased alive on <u>March 14, 1956</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>		DATE SIGNED <u>3/15/56</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				<u>HAMPSTEAD MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar 17/56</u>		<u>Grace Methodist</u>		<u>Balto co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Clifton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>3-17-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary S. Elmer</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2640 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02626

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>6 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>1411 Division Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jessie Forman Saul (Sauls)</u> First Middle Last 4. DATE OF DEATH <u>March 22</u> 19 <u>56</u> Month Day Year				5. SEX <u>F</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 1</u> 19 <u>07</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>48</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family Wilson, North Carolina</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? 			
13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Francis Griffith</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>215-30-0241</u> 17. INFORMANT <u>Jessie Artis</u> Address <u>2207 Liberty Hgts. Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anaphylactic Reaction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchitis</u> DUE TO (c) <u>Tonsillitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>24 hrs.</u> <u>24 hrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none</u> 19 <u>56</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u> 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. B. Caples</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>3-23-56</u> DATE SIGNED EXAMINER'S NAME (Type) <u>Dr. D. B. Caples</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ht. Auburn</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		24a. REC'D BY REGISTRAR <u>3-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Nancy Elmer</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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02627

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2641

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Balto	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Caton Ridge Nursing Home				STREET ADDRESS (If rural give location) Harlem Lane			
3. NAME OF DECEASED: (First) (Middle) (Last) Leon Schmidt Sr.				4. DATE OF DEATH: (Month) (Day) (Year) March 7, 1956 19			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Separated		8. DATE OF BIRTH: Aug 12, 1886	
9. AGE last birthday: 69 yrs		10. MONTHS: 6		11. DAYS: 7		12. HOURS: 19 Min.	
10A. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Poland	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-09-8707A		17. INFORMANT & ADDRESS: Mrs. Mary Torgersen 1817 E. Pratt Street	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)		Cerebro vascular accident				24 hrs	
ANTECEDENT CAUSE (B)		Arterio sclerosis Cerebral				Unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		Diabetes mellitus				Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION.		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/20, 1955 , to 3/7, 1956 , that I last saw the deceased alive on 3/6, 1956 , and that death occurred at 5th AM , from the causes and on the date stated above.							
SIGNATURE Curtis D. Duggan Jr.		M.D. 46-5		ADDRESS Edmondson		DATE SIGNED 3/9/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-9-56		NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		LOCATION (City, town, or county) (State) Balto. Md.	
DATE REC'D BY LOCAL REGISTRAR 9 1956		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR Ellsworth Arnacost		ADDRESS 4600 Liberty Heights	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02628

2642

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River 203me.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SCHUBERT</i>		d. STREET ADDRESS <i># 250 Chesapeake Ave</i>	
3. NAME OF DECEASED (Type or print) <i>AUGUSTA Louise Schubert</i>		4. DATE OF DEATH Month <i>March</i> Day <i>12</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-8-1881</i>
9. AGE (In years last birthday) <i>75</i> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wm. Tornmollen</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Holschleger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Gealia A Young</i>		Address <i>same.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>(1) Basal cell Carcinoma forehead (2) severe osteoporosis spine</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 26</i> , 19 <i>54</i> , to <i>March 12</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>March 9</i> , 19 <i>56</i> , and that death occurred at <i>9 P.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. H. Kolodny, M.D.</i>		ADDRESS (Street, city or town, state) <i>1825 Eastern Blvd Baltimore 21, Md</i>	
PHYSICIAN'S NAME (Type) <i>A. L. Kolodny, MD</i>		DATE SIGNED <i>3/13/56</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-13-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Khwarth Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Bugdzinski</i>		ADDRESS <i>1407 Eastern Ave</i>	
24a. REC'D BY REGISTRAR <i>DATE 3/14/56</i>		24b. REGISTRAR'S SIGNATURE <i>Edith Hurley</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

02629

2643

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 902 Edmondson Ave		STREET ADDRESS (If rural, give location) 902 Edmondson Ave.	
3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) SCOTT	(Last)
4. DATE OF DEATH	(Month) 3	(Day) 6	(Year) 1956
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 27, 1937
9. AGE last birthday 18 yrs.		10. AGF last birthday If under 1 year: Months 18 Days 18 Hours 18 Mins. 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Scott		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS M's Veretta Scott 902 Edmondson Av			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Fatal heart hemorrhage - possible spinal cord** **18 hrs**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Lancet's disease**

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

3 years

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Oct** 19**55**, to **March** 19**56**, that I last saw the deceased alive on **6 March, 1956**, and that death occurred at **6:00 A. m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3-9-56	NAME OF CEMETERY OR CREMATORY Western Star Cem	LOCATION (City, town, or county) Catonsville	(State) MD.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR Wm. J. ...		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		TOWN	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		5. SEX	
6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
9. AGE last birthday		If under 1 year		If under 24 hrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a)					
Antecedent cause(s) (b)					
II. OTHER SIGNIFICANT CONDITIONS					
19a. DATE OF OPERATION					
19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY?					
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.					
PLACE (Home, farm, factory, street, office, etc.)					
(CITY OR TOWN)					
(COUNTY)					
(STATE)					
TIME (Month) (Day) (Year) (Hour) OF INJURY					
INJURY OCCURRED While at work Not while at work					
HOW DID INJURY OCCUR?					
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.					
SIGNATURE (Degree or title)					
ADDRESS					
DATE SIGNED					
23. REMOVAL (Specify)					
DATE THEREOF					
NAME OF CEMETERY OR CREMATORY					
LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR					
ADDRESS					



2645 **CERTIFICATE OF DEATH**

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>5 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>Route #1, Box 317</u>					
3. NAME OF DECEASED (Type or Print) <u>WILLIAM R. SEDGWICK</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>February 2, 1893</u>	9. AGE last birthday <u>63</u> yrs	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>56</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical Company</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Horace Sedgwick</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Offeri</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>215-07-7860</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vat. Adm. Hospital, Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
/ <u>IMMEDIATE CAUSE (A) <u>CARCINOMA OF THE BILIARY TRACT</u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>ANTECEDENT CAUSE(S) DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 2, 1956</u>, to <u>March 7, 1956</u>, and that death occurred at <u>1:30AM</u>, from the causes and on the date stated above SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>FRANCIS G. DICKIEY, M.D., Chief, Medical Service VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>3/7/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/12/57</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>12 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Isaiah Brown Funeral Home</u>		ADDRESS <u>108 Montgomery St. Baltimore, Maryland</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 Hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

U.S. AIR FORCE

MAR

1954

2646

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>501 RIVERSIDE DRIVE</u>		d. STREET ADDRESS <u>501 RIVERSIDE DRIVE</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CAROLINE</u> First <u>M. SCHOOK</u> Middle Last		4. DATE OF DEATH <u>MARCH</u> Month <u>25</u> 19 <u>56</u> Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 13, 1887</u>
9. AGE (In years last birthday) <u>68</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN KOENIG</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN WOLFE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>179-16-6832</u>	
17. INFORMANT <u>LEROY E. GERDING ATT.</u> Address <u>220 S. HIGHLAND AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>arterio-sclerotic heart disease</u> (b) <u>arterio-sclerotic heart disease</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>8 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/10/47</u> 19 <u>47</u> to <u>3/25/56</u> 19 <u>56</u> that I last saw the deceased alive on <u>11/30/55</u> 19 <u>55</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>423 Eastern Ave Pkx 2142 3/26/56</u> DATE SIGNED <u>3/26/56</u>			
ACTUAL SIGNATURE <u>Joseph Miceli</u>		PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>3/27/56</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>SUNBURY, PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Brudzinski</u> ADDRESS <u>1407 Eastern Ave</u>		24a. REC'D BY REGISTRAR DATE <u>3/26/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

S. A. O'NEILL

1897



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02633

2647

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown, Md.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 42 Westminster Road				d. STREET ADDRESS 42 Westminster Road			
3. NAME OF DECEASED (Type or print) Anna First Kathence Middle Shamberger Last				4. DATE OF DEATH March 9 Day 9 Year 19 56			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1885	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT Mrs. John Wynn Morgonton, North Carolina Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 470.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 years						INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 13 , 19 54 , to March 9 , 19 56 , that I last saw the deceased alive on March 5 , 19 56 , and that death occurred at M , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James S. Williams M.D. March 13, 1956 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 12, 56		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Son's Reisterstown, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE 3-10-56		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

BUCKLE V. 2

8

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02634

Reg. Dist. No.

Items 8, 9, Film 11-5-1-16-56 et

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3202 Barrington Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AARON Middle SHULMAN Last SHULMAN		4. DATE OF DEATH Month March Day 25 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/9/1911-1-03
9. AGE (In years last birthday) 53 5/8 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furrier	
10b. KIND OF BUSINESS OR INDUSTRY Fur		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Shulman	
14. MOTHER'S MAIDEN NAME Rachel Schweisberg		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW II	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet Adm Hospital, Fort Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYOCARDIAL INFARCTION			INTERVAL BETWEEN ONSET AND DEATH 15 Minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		20g. (County) (State)	
21. I certify that I attended the deceased from March 21, 1956 to March 25, 1956 and that death occurred at 10:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Rafael Longo		DATE SIGNED 3/25/56	
PHYSICIAN'S NAME (Type) RAFAEL LONGO, M. D.		ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-26-56	22c. NAME OF CEMETERY OR CREMATORY United Hebrew Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Jacob Lewis		24a. REC'D BY REGISTRAR 2100 Eastview Place	
24b. REGISTRAR'S SIGNATURE Samuel L. Larkins		DATE	

IS A COPY

1956

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2649

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Owens Mills</u>		RURAL LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Swynbrook Ave</u>				STREET ADDRESS (If rural give location) <u>2508 E Madison St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>DOROTHY ELIZABETH SISELBERGER</u>				<u>March 24 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>October 13 1904</u>	
9. AGE last birthday: <u>51</u> yrs.		10. MONTHS <u>1</u> DAYS <u>24</u> HOURS <u>19</u> MIN.		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Mr. R. R. R. R.</u>				14. MOTHER'S MARRIAGE NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
				17. INFORMANT & ADDRESS: <u>Mr. Harry Sisselberger 2508 E. Madison St. Baltimore, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
163x Immediate cause (a) <u>Carcinoma, pulmonary</u>							
Antecedent causes (s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 23, 1956</u> , to <u>March 24, 1956</u> , that I last saw the deceased alive on <u>March 24, 1956</u> , and that death occurred at <u>4:25 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Clarence E. McWilliams M.D.</u>				DATE SIGNED <u>March 24, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 26, 1956</u>		<u>Baltimore Cemetery</u>		<u>Balto. Md.</u>	
DATE RECD BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-27-56</u>		<u>[Signature]</u>		<u>John C. Miller Inc.</u>		<u>2431 E. Oliver St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MW3. Page 5 may be retained for your files. **FINAL DIRECTOR** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2650 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02636

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7mos. 10days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 2827 Bauernwood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Andrew Middle Herbert Last Slaughter				4. DATE OF DEATH Month March Day 27, Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-1877	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Mr. James Slaughter				14. MOTHER'S MAIDEN NAME Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 218-12-2580		17. INFORMANT Records Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cardiac failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 904.7 DUE TO (b) Hypertensive cardiovascular disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left hip 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Undetermined					
20c. TIME OF INJURY Month, Day, Year Hour a. m. Unknown 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.							
ACTUAL <i>George S. M. Kieffer</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 3-27-56			
EXAMINER'S NAME (Type) George S. M. Kieffer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/56		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road				24a. REC'D BY REGISTRAR <i>April 2, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>T. E. Harry</i>	

U. S. 1000000

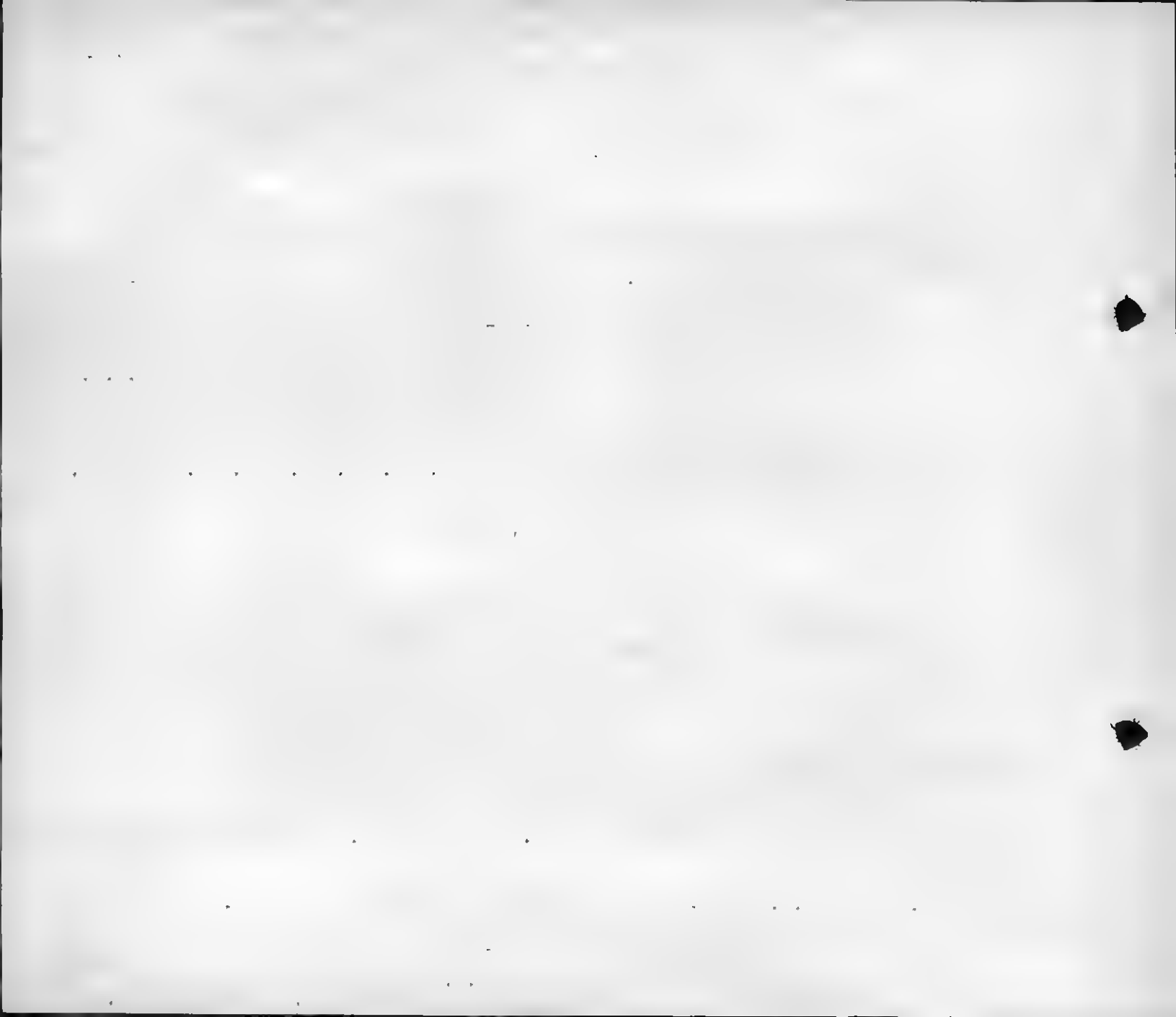
2651 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Fort Howard</u> TOWN <u>5 Days</u> LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore</u> TOWN _____ STREET ADDRESS (If rural give location) <u>3414 Juneway</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES W. SLITZER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 5, 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7-28-95</u>
9. AGE last birthday: <u>60</u> YRS		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Policeman</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Lewis Slitzer</u>		14. MOTHER'S MAIDEN NAME: <u>Josephine Bamberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk. (If Yes, give war or dates of service)) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>LAENNEC'S CIRRHOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
IMMEDIATE CAUSE (A) <u>LAENNEC'S CIRRHOSIS</u>		DUE TO	
ANTECEDENT CAUSE (B) _____		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that <u>VA</u> attended the deceased from <u>Feb. 29, 1956</u> to <u>Mar. 5, 1956</u> and that death occurred at <u>5:55 P</u> M. from the causes and on the date stated above. SIGNATURE <u>Francis G. Dickey</u> ADDRESS _____ DATE SIGNED _____			
FRANCIS G. DICKEY, M.D., Chief, Medical Service, VAH, Fort Howard, Md. 3-6-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/8/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 7, 1956</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>M.F. SADOWSKI & SONS</u>		ADDRESS <u>1800 Eastern Ave., Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2652

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3018 Hiss Avenue				d. STREET ADDRESS 6513 Harford Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mr. David J. Middle J. Last Smith			4. DATE OF DEATH Month March Day 20th Year 1956				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1876		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME Ann				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-5360		17. INFORMANT Address Mr. Henry Smith, 3018 Hiss Avenue #14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL DEGENERATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY OCCLUSION (1941) DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1941, to Mar. 21, 1956 , that I last saw the deceased alive on Mar. 10, 1956 , and that death occurred at 11A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. M. Bacon			ADDRESS (Street, city or town, state) 2810 TAYLOR-BALTO. 14				
PHYSICIAN'S NAME (Type) G. M. BACON			DATE SIGNED 3/21/56				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/1956		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14				24a. REC'D BY REGISTRAR DATE 3/21/56		24b. REGISTRAR'S SIGNATURE G. M. Bacon	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 10 days after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02639

2653

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frederick</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Home 3700</u>				STREET ADDRESS (If rural give location) <u>1717 N. Frederick</u>			
3. NAME OF DECEASED (Type or Print) <u>Line</u> (First) <u>Frederick</u> (Middle) <u>Frederick</u> (Last)				4. DATE OF DEATH (Month) <u>5</u> (Day) <u>30</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 7, 1924</u>		9. AGE last birthday <u>31</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Dröhan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Roche</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S ADDRESS <u>Frank L. Smith Jr. Cockeysville Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH <u>876.2</u>	
IMMEDIATE CAUSE (A) <u>Cancer - Abdominal</u>							
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1446</u>, 19<u>56</u>, to <u>3/3</u>, 19<u>56</u>, that I last saw the deceased alive on <u>3/3</u>, 19<u>56</u>, and that death occurred at <u>2:50 P.</u>M, from the causes and on the date stated above.							
SIGNATURE <u>Frank L. Smith Jr.</u>				ADDRESS (Street, city, town, state) <u>Cockeysville Md.</u>		DATE SIGNED <u>3/30/56</u>	
				M.D.			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Apr 2-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Frank L. Smith Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Tom Gore Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	
DATE							



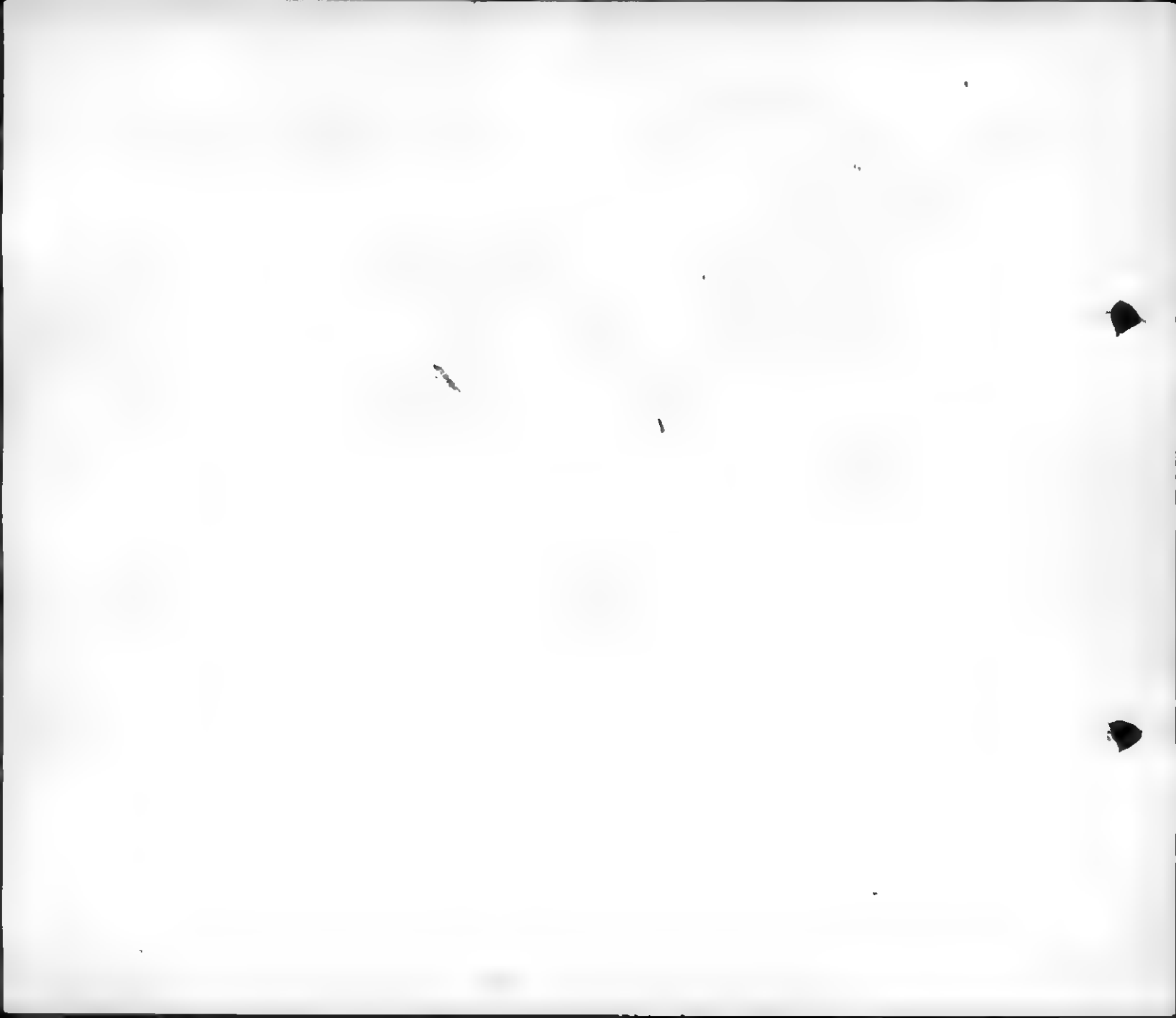
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02640

2654 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE CITY</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>RURAL - VILLANOVA</u>		<u>20 MONTHS</u>		OR TOWN <u>BALTIMORE</u>			
HOSPITAL OR ROBB NURSING HOME				STREET ADDRESS (If rural give location)			
INSTITUTION OR STREET ADDRESS <u>4105 ESSEX RD. BALTO.</u>				ADDRESS <u>5 W. FORT AVE</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
First (Middle) (Last) <u>HATTIE DORA SNYDER</u>				OF DEATH: <u>3</u> <u>13</u> <u>1956</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>JAN. 18, 1878</u>	
9. AGE last birthday: <u>78</u> yrs		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>							
13. FATHER'S NAME: <u>JOHN HENRY MACIE</u>				14. MOTHER'S MAIDEN NAME: <u>REBECCA ZIMMERMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>NO</u>				16. SOCIAL SECURITY NO. <u>4</u>		17. INFORMANT & ADDRESS: <u>SON - WM. H. SNYDER.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Apoplexy</u>							<u>2 days</u>
ANTECEDENT CAUSE (B) <u>Hypertensive C.V. Disease</u>							<u>50 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 1954, to <u>March 13</u> , 1956, that I last saw the deceased alive on <u>3/12</u> , 1956, and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edwin J. Poirson</u>				ADDRESS <u>8704 Liberty Rd, Balto, Md</u> DATE SIGNED <u>3/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3/16/56		Zion Cem.		Loganville, Md. Penna. Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>B-7-K-56</u>		<u>Edwin J. Poirson</u>		<u>Wm. J. Poirson & Sons - Balto 17</u>		<u>17</u>	



2655

CERTIFICATE OF DEATH

Reg. Dist. No. 37

Inter 2, Film 9194 4-2-56 et

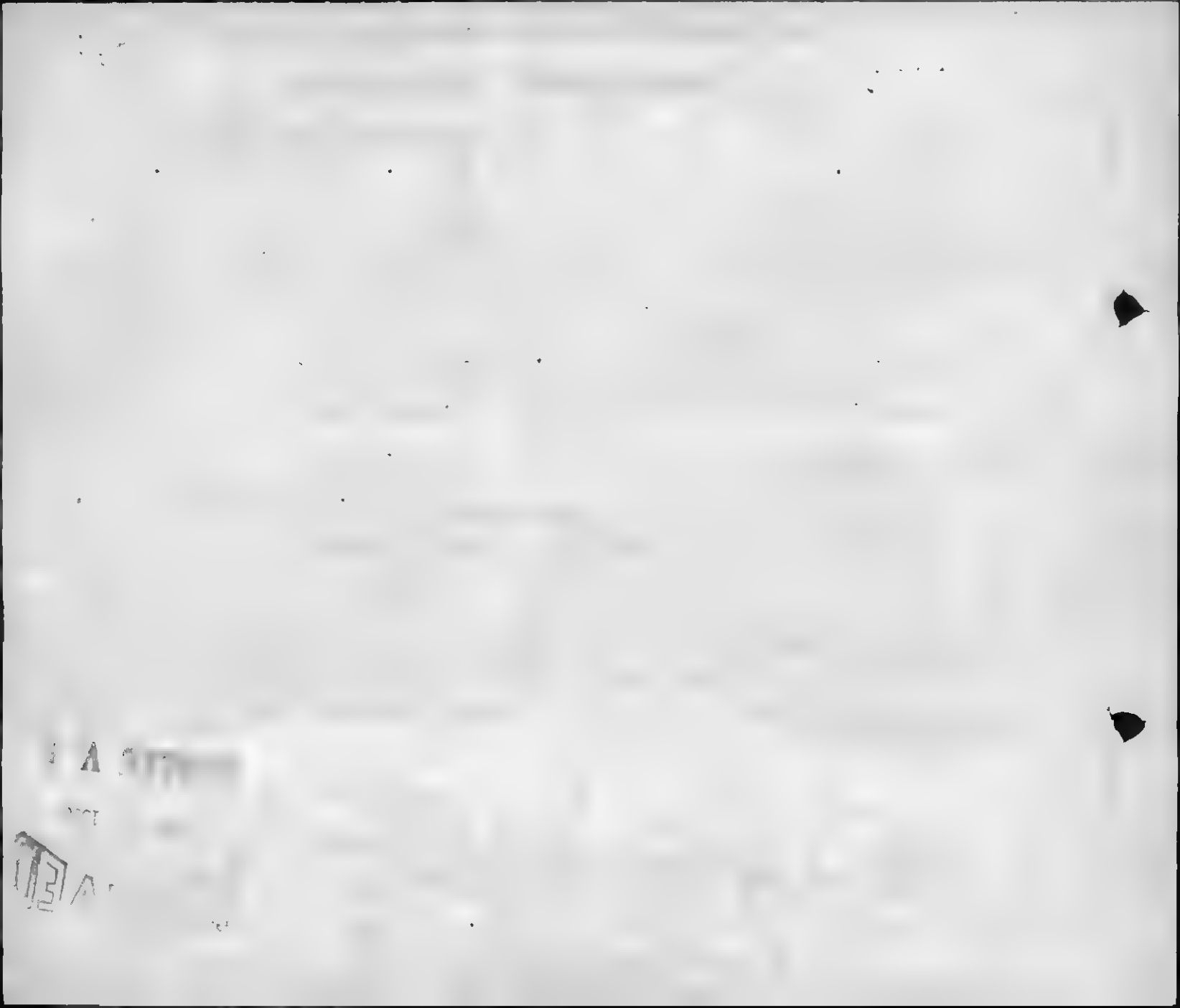
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		STATE <u>Md.</u>		COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor Nursing Home</u>		STREET ADDRESS <u>College Manor 106 Croydon Road</u>					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOHN PAUL SNYDER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 20, 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov. 30, 1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Donultant (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmaceutical</u>		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Martin Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Anna C. Hunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. John M. Snyder-106 Croydon Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Pulmonary insufficiency Emphysema			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-17-56</u> to <u>5-17-56</u> , that I last saw the deceased alive on <u>3-17-56</u> , and that death occurred at <u>6:41</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>William F. Juli</u>				ADDRESS (Street, city, town, state) <u>Washington, D. C.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial - removed</u>		DATE THEREOF <u>3/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. REC'D BY REGISTRAR <u>Anna MacRae</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Balto 17th</u>		ADDRESS	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02642

2656

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH: Baltimore
County.....
City or town Howardville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 63 Years
Hospital, institution, or street address where death occurred:
Campfield Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Howardville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Campfield Road
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME
MUSADORA SNYDER

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single married, widowed, or divorced Widowed
6.(b) Name of husband or wife xx Henry G. Snyder
7. Birth date of deceased (mo., day, yr.) March, 27th. 1873
8. AGE: Years 82 Months 11 Days 20 If less than one day
.....hrs.min.

9. Birthplace Winfield, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

12. Name Price Criswell

13. Birthplace

14. Maiden name Susana Hoffman

15. Birthplace

16. Informant Mrs Katherine Bowling

Address Campfield Road, Howardville

17. Burial Date thereof March, 21 1956
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt. Olive Cemetery

Location Randallstown, Maryland.

18. Funeral director Thomas Lawrence

Address 4510 Liberty Heights Ave.

19. 5/20 19 56 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March, 18th 19 56 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from JUNE 19 53 to March 18th 19 56

and that I last saw h.e. alive on March 18th 19 56

Immediate cause of death Uremia DURATION 2 wks

Due to Chronic Nephritis 2 yrs.

Due to Art. Sclerosis 3 yrs.

Other conditions Hypertension 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

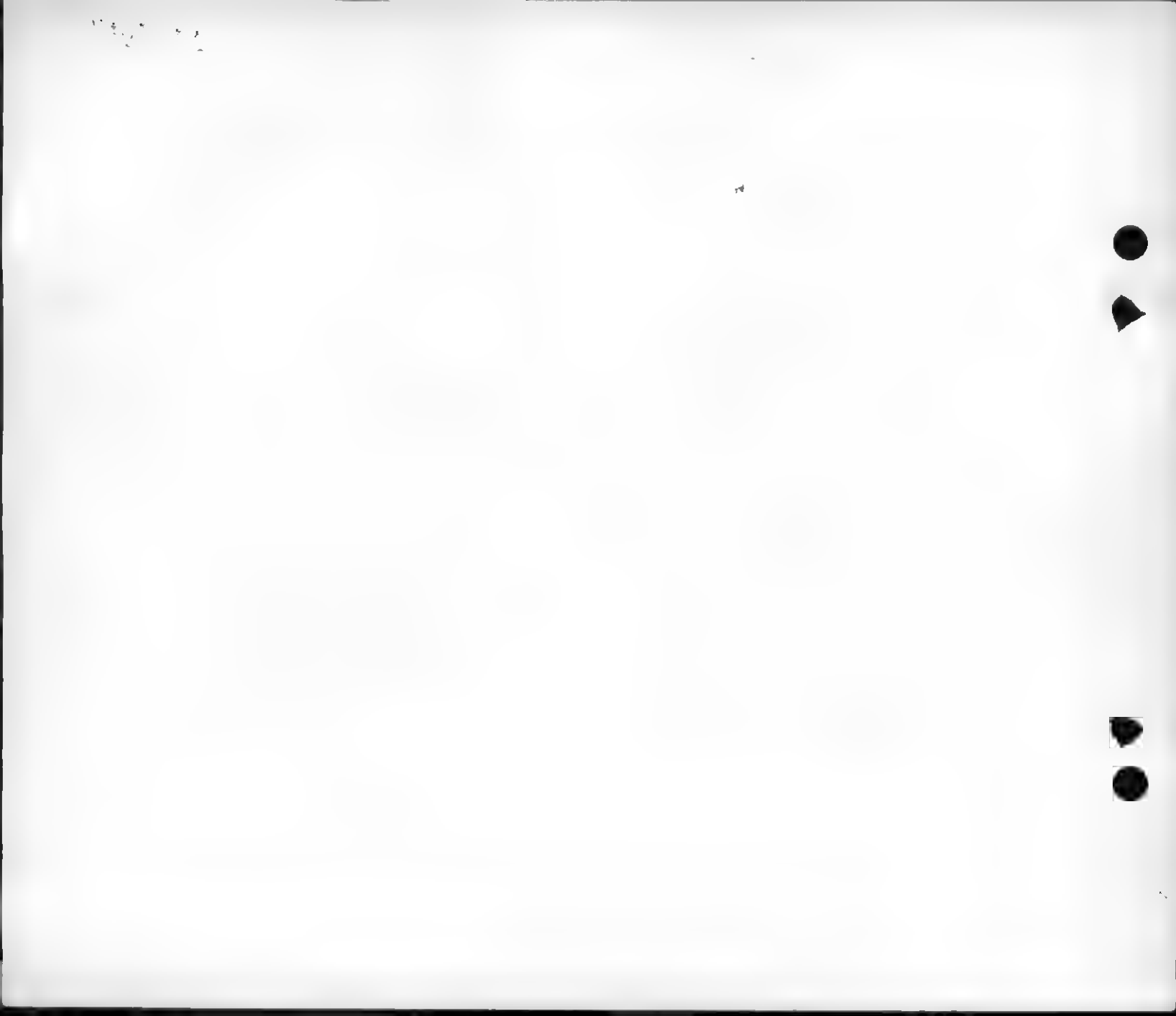
23. SIGNATURE James A. Miller M.D. or other

Registerstown Rd. & Walker Ave Mar. 19/56
Address Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coverage is especially important. Physicians: please write the causes of death clearly and legibly.



2657 CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Twyn Oak</u>	LENGTH OF STAY (In this place) <u>8 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto</u>	<u>3 vol-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hugsburg Home</u>		STREET ADDRESS (If rural give location) <u>2002 E. Lafayette Ave</u>	
3. NAME OF DECEASED: (Type or Print) <u>Lizette</u> (First) (Middle) (Last) <u>Immelborn</u>		4. DATE OF DEATH: (Month) <u>3</u> (Day) <u>27</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widow</u>	8. DATE OF BIRTH: (Month) <u>Apr</u> (Day) <u>12</u> (Year) <u>1873</u>
10A. USUAL OCCUPATION (Give kind of work done during last of working life even if retired) <u>Home</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country): <u>Balto md</u>
13. FATHER'S NAME: <u>Henry Weller</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT & ADDRESS: <u>Mary Frank</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	DUE TO <u>Carcinoma (G.I. tract.)</u>	<u>6 months</u>
ANTECEDENT CAUSE (B)	DUE TO <u>Arterio-sclerotic Heart Disease</u>	<u>5 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		
(C) <u>Chronic Gall Bladder</u>		<u>6 yrs.</u>

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION: <u>Dec. - 1951 -</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Rt. Breast - Removed (Cancer)</u>	20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>5/10</u> , 1949, to <u>3/27</u> , 1956, that I last saw the deceased alive on <u>3/22</u> , 1956, and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.	
SIGNATURE <u>Paul D. Chambers</u>	ADDRESS <u>Baltimore</u> DATE SIGNED <u>3/27/56 - Jm</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>3/29/56</u>
NAME OF CEMETERY OR CREMATORY <u>Western Ave</u>	LOCATION (City, town, or county) <u>Balto</u>
DATE REC'D BY LOCAL REGISTRAR <u>3/29/56</u>	REGISTRAR'S SIGNATURE <u>Paul D. Chambers</u>
24. FUNERAL DIRECTOR <u>Paul D. Chambers</u>	ADDRESS <u>6087 Hartford Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8-8
281
3-8
9-14

2658

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1508 Midvale Ave</u>				d. STREET ADDRESS <u>1508 Midvale Ave</u>			
3 NAME OF DECEASED (Type or print) <u>MINNIE-LOUISE STANDIFORD</u>				4. DATE OF DEATH <u>March 26 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV-3-1880</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>KENT Co - MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Sewell</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Rash</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Sara R. Davis</u> Address <u>1508 Midvale Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Oct. 19 49</u> to <u>March 19 56</u> that I last saw the deceased alive on <u>March 25 19 56</u> and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>L. J. Gaver</u> M.D. <u>1 Hollow Hill Ave., Baltimore, Md.</u> <u>3/26/56</u> PHYSICIAN'S NAME (Type) <u>LEO J. GAVEL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 29 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) <u>Balto Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Grefel</u> ADDRESS <u>5311 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR <u>DATE 3/27/56</u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM V. S.

1871

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2659

CERTIFICATE OF DEATH

Reg. Dist. No.

02645

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 26yr. 2mos. 4days			
d. NAME OF HOSPITAL (If not in hospital, give street address) 14 Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter W/LADYSLAW/ Stefanawich				4. DATE OF DEATH March 7, 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-11-1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lithuania				12. CITIZEN OF WHAT COUNTRY? Unknown			
13. FATHER'S NAME Napoleon Stefanawich				14. MOTHER'S MAIDEN NAME Catherine ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never; unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records Spring Grove State Hospital Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-3- 19 29 , to 3-7- 19 56 that I last saw the deceased alive on 3-7- 19 56 , and that death occurred at 12:45PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 3-7-56							
ACTUAL SIGNATURE T. Glyne Williams M.D.				PHYSICIAN'S NAME (Type) T. Glyne Williams, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 10/56		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Ozagowski ADDRESS 1930 Eastern Ave.				24a. REC'D BY REGISTRAR DATE 8 1956		24b. REGISTRAR'S SIGNATURE T. E. Glyne	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After it is signed, the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHN A. V. S.

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2660

CERTIFICATE OF DEATH

02646

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Belinda Ave.				d. STREET ADDRESS 3 Belinda Ave.			
3. NAME OF DECEASED (Type or print) Edward H. Stegman				4. DATE OF DEATH Month March Day 8 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4, 1894	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef				10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Conrad Stegman				14. MOTHER'S MAIDEN NAME Anna Blanke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-16-0214		17. INFORMANT Mrs. Albert Alms-3 Belinda Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma & Hypoproteinemia Severe DUE TO 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ascites and drainage. 3.4 wks. (c) Portal Cirrhosis, hamme type Severe ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exploratory laparotomy By Dr Camp at Union Memorial Hosp. East. Wash.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3 Mar. 1956 to 8 Mar. 1956 , that I last saw the deceased alive on 7 Mar. 1956 , and that death occurred at 8:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7527 Belair Rd. Baltore DATE SIGNED 3/9/56							
ACTUAL SIGNATURE John C. Hyle				M.D. 7527 Belair Rd. Baltore			
PHYSICIAN'S NAME (Type) JOHN C. Hyle							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-1956		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lanahan Funeral Home				ADDRESS 7401 Belair Rd.		24b. REC'D BY REGISTRAR Mrs. L. L. Reifsnider	

BUREAU N. S.

MAR 12 1900

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used only on burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V5 AISM(E)S
5M 9/55

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2661 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02647

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b 8 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis (Rural-Eastport)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Edward Last Stevens				4. DATE OF DEATH Month March Day 30 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1868	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 87 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Fuller E. Stevens				14. MOTHER'S MAIDEN NAME Elizabeth Cauritt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left femur						INTERVAL BETWEEN ONSET AND DEATH years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell on hospital ward					
20c. TIME OF INJURY Month, Day, Year Mar 20 1956 Hour 9 a. m. 00		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital Ward		20f. (City or town) (County) (State) Catonsville Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George S. M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/31/56			
EXAMINER'S NAME (Type) George S. M. Kieffer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 3, 56		22c. NAME OF CEMETERY OR CREMATORY Davidsonville Methodist		22d. LOCATION (City, town, or county) (State) Davidsonville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS ANNAPOLIS, MD.		24a. RECEIVED BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE J. E. Harry			

MEDICAL CERTIFICATION

BUNTING V. S.

APR 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 9, Filmed 5-1-68 at

2662

CERTIFICATE OF DEATH

Reg. Dist. No.

02648

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson				c. LENGTH OF STAY IN 1b 174 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Coombs Last Stewart				4. DATE OF DEATH Month Mar Day 23 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21, 1882	
9. AGE (In years last birthday) 73 7/8 yrs.		IF UNDER 1 YEAR Months 7 Days 2 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Garage				10b. KIND OF BUSINESS OR INDUSTRY Owner			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Tone A. Stewart				14. MOTHER'S MAIDEN NAME Laura V. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Hospital Records, Mt. Wilson, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 002X DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 22, 1955 to Mar 22, 1956 that I last saw the deceased alive on Mar 22, 1956 and that death occurred at 6:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Newcomer M.D.				ADDRESS (Street, city or town, state) Mt. Wilson, Maryland			
DATE SIGNED							
PHYSICIAN'S NAME (Type) WILLIAM NEWCOMER, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE 3/15/56		24b. REGISTRAR'S SIGNATURE Dorothy Newell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with in 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02649

CERTIFICATE OF DEATH

Reg. Dist. No.

38

2663

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Nursing Home Bosely and Chesapeake Ave.		d. STREET ADDRESS 3504 Ailsa Avenue	
3. NAME OF DECEASED (Type or print) Mr. George W. Streat		4. DATE OF DEATH March 19th 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1869 ?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Candler Building		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Nanticoke, Maryland		12. CITIZEN OF WHAT COUNTRY? MSA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-09-3014	
17. INFORMANT Mr. William J. Streat, 1116 S. Alfred Street		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decomposition Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 15, 1956 to March 18, 1956 , that I last saw the deceased alive on March 18, 1956 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post M.D.		DATE SIGNED 6805 York Rd.	
PHYSICIAN'S NAME (Type) LAARENCE C. Post		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/22/1956	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE 2-23-56	
		24b. REGISTRAR'S SIGNATURE Mark Gray	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3-21

100

7-21

2664

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Pasadena</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shady Nook Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Mountain Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MAE</u> <u>BERFIELD</u> <u>SWETLAND</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar.</u> <u>13,</u> <u>19</u> <u>56</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>May 24, 1872</u>	
9. AGE last birthday: <u>83</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country): <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Francis Marion Berfield</u>				14. MOTHER'S MAIDEN NAME: <u>Almina Nelson Berfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Md.</u> <u>Mr. C. B. Nairn - Mountain Rd., Pasadena</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pneumonia</u>						<u>1 week</u>	
ANTECEDENT CAUSE (B) <u>173 infection</u>						<u>year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>arterio-sclerosis</u>						<u>year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION.				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>3/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>56</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>3/14/56</u>		M. D. <u>119 St. and I - 220-2</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Eulalia</u>		LOCATION (City, town, of county) (State) <u>Coudersport, Penna.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-18-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2665

CERTIFICATE OF DEATH

Reg. Dist. No.

02651

74

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 80 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BRIGHT Middle E. Last THARPE				4. DATE OF DEATH Month March Day 23 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1892		9. AGE (In years last birthday) 63 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rock County, Texas	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Charles Tharpe				14. MOTHER'S MAIDEN NAME Tony Lamb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 263-22-2057			
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RUPTURED DUODENAL ULCER WITH GENERALIZED PERITONITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchogenic Carcinoma, Left Lung							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 3, 1956 , to March 23, 1956 , and that death occurred at 8:08 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 3-23-56							
ACTUAL SIGNATURE Donald D. Mark M.D. VAH, FORT HOWARD, MARYLAND 3-23-56							
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 11, Md.				24a. REC'D BY REGISTRAR DATE			
24b. REGISTRAR'S SIGNATURE Dawson L. Lasker							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALBUQUERQUE, N. M.

8 1953

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, written "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2666 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02652-45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glen L. Martin Plant Hospital</u>		d. STREET ADDRESS <u>11 N. Streeper St.</u>	
3. NAME OF DECEASED (Type or print) <u>William Marion Theisz Sr.</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24, 1907</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stockkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Theisz</u>		14. MOTHER'S MAIDEN NAME <u>Mary Aires</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-2101</u>	
17. INFORMANT <u>Mrs. Louise Theisz</u>		Address <u>11 N. Streeper St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/21/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-22-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dabrowski</u>		ADDRESS <u>2818 E. Baltimore St.</u>	
24a. REC'D BY REGISTRAR <u>March 21, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Edith Hurley</u>	

U. S. A.

1900

1900

02653

CERTIFICATE OF DEATH

2667

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u> <u>Paradise Ave. & Altamont Rd</u>				STREET ADDRESS (If rural give location) <u>515 Rock Glen Road</u>			
3. NAME OF (First) (Middle) (Last) (Type or Print) <u>Sophia F. Tinley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 3/56</u> 19			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>June 4, 1875</u>	9. AGE last birthday <u>80</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Heinrich Cran</u>				14. MOTHER'S MAIDEN NAME <u>Florentina Bruckmann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Arthur Gladmon, 515 Rock Glen Rd</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pneumonia, bilateral (Broncho-pneumonia)</u>						3 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive Cardio-vascular Disease</u>						5 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 51</u> , to <u>March 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>56</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>MD 1 Mallow Hill Ave., Baltimore 29, Md</u>		DATE SIGNED <u>3/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 6/56</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>Mar. 7, 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>101 Edmondson Ave</u>	

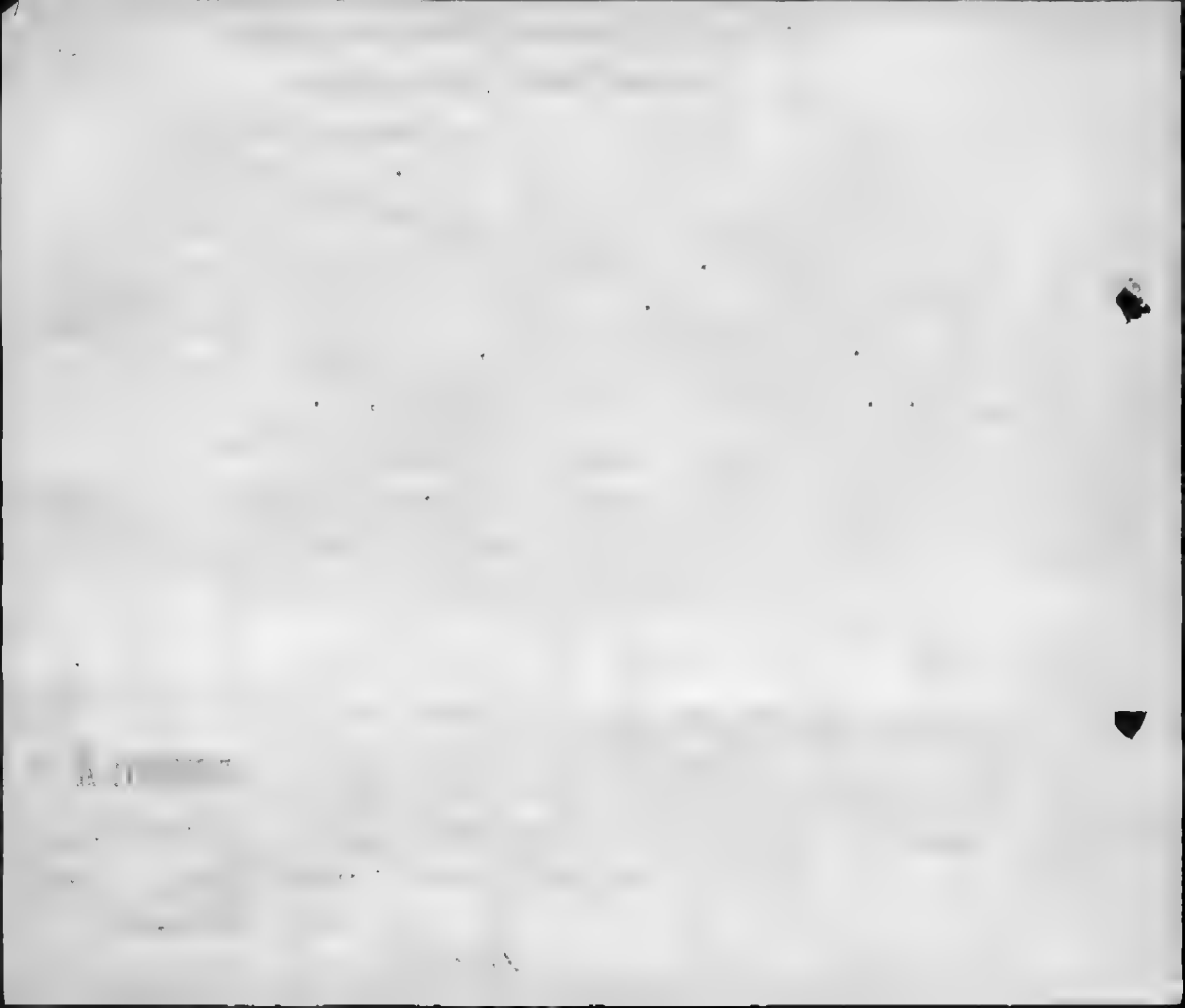
1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2668				02654			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN Reisterstown		35 yrs		TOWN Reisterstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
Glen Falls Road				Glen Falls Road			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH			
(Type or Print) Charles L. Uhler				March 19, 1956 19			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Single	Sept. 22, 1872	83 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Farmer				Md.		U.S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Charles W. Uhler				Sallie A. Lorey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No		None		Mrs. Maggie Uhler, Reisterstown, Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) ... Coronary Artery Disease						3 hrs.	
DUE TO							
Antecedent cause(s) (b) ...							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
none				none			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY none		21c. (City or town, (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY none		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? none			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
L. J. Taylor		Mar. 22, 1956		Finksburg		Carroll County	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Mar. 22, 1956		Finksburg		Carroll County	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3-20-56		Mary S. Taylor		J.F. Eline & Sons, Reisterstown, Md.			

1925

1925

1925

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

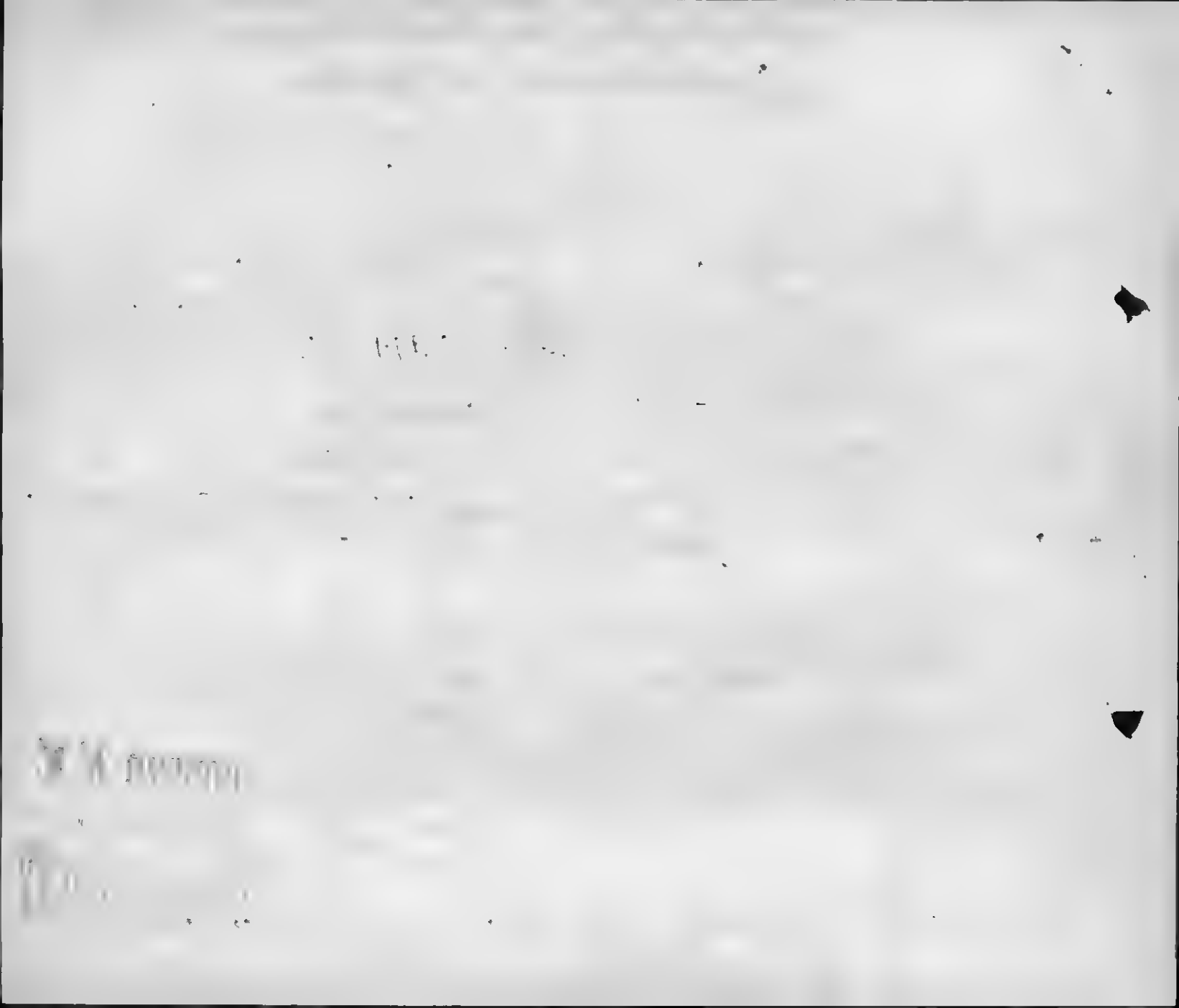
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02655

2659 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		STATE Md.		COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore - 12		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore - 12			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 500 Murdock Rd.				STREET ADDRESS (If rural give location) 500 Murdock Rd. Zone 12			
3. NAME OF DECEASED (Type or Print) ANGELO (First) VICARI (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) Mar. 28, 1956			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH April 20, 1874	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commission Merchant - Fruit		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Michael Vicari				14. MOTHER'S MAIDEN NAME Rose Jeroshi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. R. Louise Vicari-500 Murdock Rd.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Gastro Intestinal Hemorrhage, - Duodenal Ulcer				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 10, 1948 , to March 28, 1956 , that I last saw the deceased alive on March 28, 1956 , and that death occurred at 8 P. M., from the causes and on the date stated above.							
SIGNATURE Lawrence C. Posh		M.D. 6805 York Rd - Baltimore 12 Ind		DATE SIGNED 3-29-56			
23. BURIAL, CREMATON, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/31/56		NAME OF CEMETERY OR CREMATORY Western Cem.		LOCATION (City, town, or county) (State) Balto., Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Theresa J. ...		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Balto		ADDRESS Md.	
DATE 1956							



Item 13, Film 195 1-11-56, et

2670

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	STATE <u>Md</u> COUNTY <u>BALTO</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>NO CLEARWOOD RD</u>	LENGTH OF STAY (in this place) <u>2 yrs</u>	STREET ADDRESS (If rural give location) <u>1501 CLEARWOOD RD</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>VINCENT IGNATIUS WALTER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 28 1956</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>FEB 14-1890</u>
9. AGE last birthday <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (State or foreign country): <u>Md</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if not now) <u>MACHINIST</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Boiler Works</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Vincent Ignatius Walter, Sr.</u>		14. MOTHER'S MAIDEN NAME: <u>MARIE GALLAGHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>18-01-8110</u>	
17. INFORMANT'S ADDRESS: <u>MARY F. GILLIS 1501 CLEARWOOD RD</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of Pancreas</u>			<u>8-10</u>
ANTECEDENT CAUSE (S) (B) <u>and metastasis to liver and Intestines</u>			<u>months</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Feb 2, 1956</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Ca. of Pancreas, Liver, Intestines</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from August, 1955, to March, 1956, that I last saw the deceased alive on March 28, 1956, and that death occurred at 5 ^{LE} P.M. from the causes and on the date stated above.			
SIGNATURE <u>W. Meredith Smith</u>		DATE SIGNED <u>March 28, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/31/56</u>	
NAME OF CEMETERY OR CREMATORY <u>LORRAINE GEM</u>		LOCATION (City, town, or county) <u>WOODLAWN Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/29/56</u>		REGISTRAR'S SIGNATURE <u>W. Meredith Smith</u>	
24. FUNERAL DIRECTOR <u>W. Meredith Smith</u>		ADDRESS <u>6305 The Alameda</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100

100

100

2671 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH. <u>ROSEWOOD TRAINING SCHOOL</u>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u> MARYLAND		STATE <u>MD.</u> COUNTY <u>Cecil</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELKTON Md.</u>		STREET ADDRESS (If rural give location) <u>AEISTERTOWN RD.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>OWINGS MILLS</u>		LENGTH OF STAY (in this place) <u>3 Y 10 M</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ROSEWOOD TRAINING SCHOOL</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>PAUL</u> <u>LEROY</u> <u>WARD</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MARCH 4 1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>S.</u>	8. DATE OF BIRTH: <u>7-12-46</u>	9. AGE last birthday: <u>9</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>ALVIN LEROY WARD.</u>				14. MOTHER'S MAIDEN NAME: <u>MARIAN WILLIAMS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>HOSPITAL RECORDS.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARDIAC FAILURE.. (ACUTE)</u>							
ANTECEDENT CAUSE (B) <u>SEVERE PNEUMONIA.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>HYDROCEPHALY, SECONDARY ANEMIA</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>NO</u>		19B. MAJOR FINDINGS OF OPERATION: <u>NO</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory) OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-1, 1952</u> , to <u>3-4, 1956</u> , that I last saw the deceased alive on <u>3-4, 1956</u> , and that death occurred at <u>6:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Charles E. Anala</u>		ADDRESS <u>2920 N. Calvert</u>		DATE SIGNED <u>3-4-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Friends</u>		LOCATION (City, town, or county) (State) <u>Calvert, Cecil Co Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1956</u>		REGISTRAR'S SIGNATURE <u>Mary Clancy</u>		24. FUNERAL DIRECTOR <u>Joseph R. Hunt North East</u>		ADDRESS <u>no</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. A. RYDING



2672

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT HOWARD</u>				c. LENGTH OF STAY IN 1b <u>39 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>VETERANS ADMINISTRATION HOSPITAL</u>				d. STREET ADDRESS <u>231 N. CARLTON STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>(NEI)</u> Last <u>WARDLAW</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-26</u>	9. AGE (In years last birthday) <u>29 yrs</u>	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAREHOUSEMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>WILLIAM WARDLAW</u>			
14. MOTHER'S MAIDEN NAME <u>MAGGIE CHILDS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>			
16. SOCIAL SECURITY NO. <u>217-12-6074</u>				17. INFORMANT <u>CLIL. REC. VET. ADM. HOSP. FT. H. WARD, MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MALIGNANT NEPHROSCLEROSIS</u> <u>401</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>FEB. 12, 1956</u> , to <u>MARCH 22, 1956</u> , that I declared the deceased <u>dead</u> , and that death occurred at <u>8:05 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald D. Mark</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u>				DATE SIGNED <u>3-22-56</u>			
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles G. Cooper</u> ADDRESS <u>512 N. Carrollton Avenue, Balto., Md.</u>				24a. REC'D BY REGISTRAR <u>Apr 2, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Fisher</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM K. S.

APR

REC-1

2673

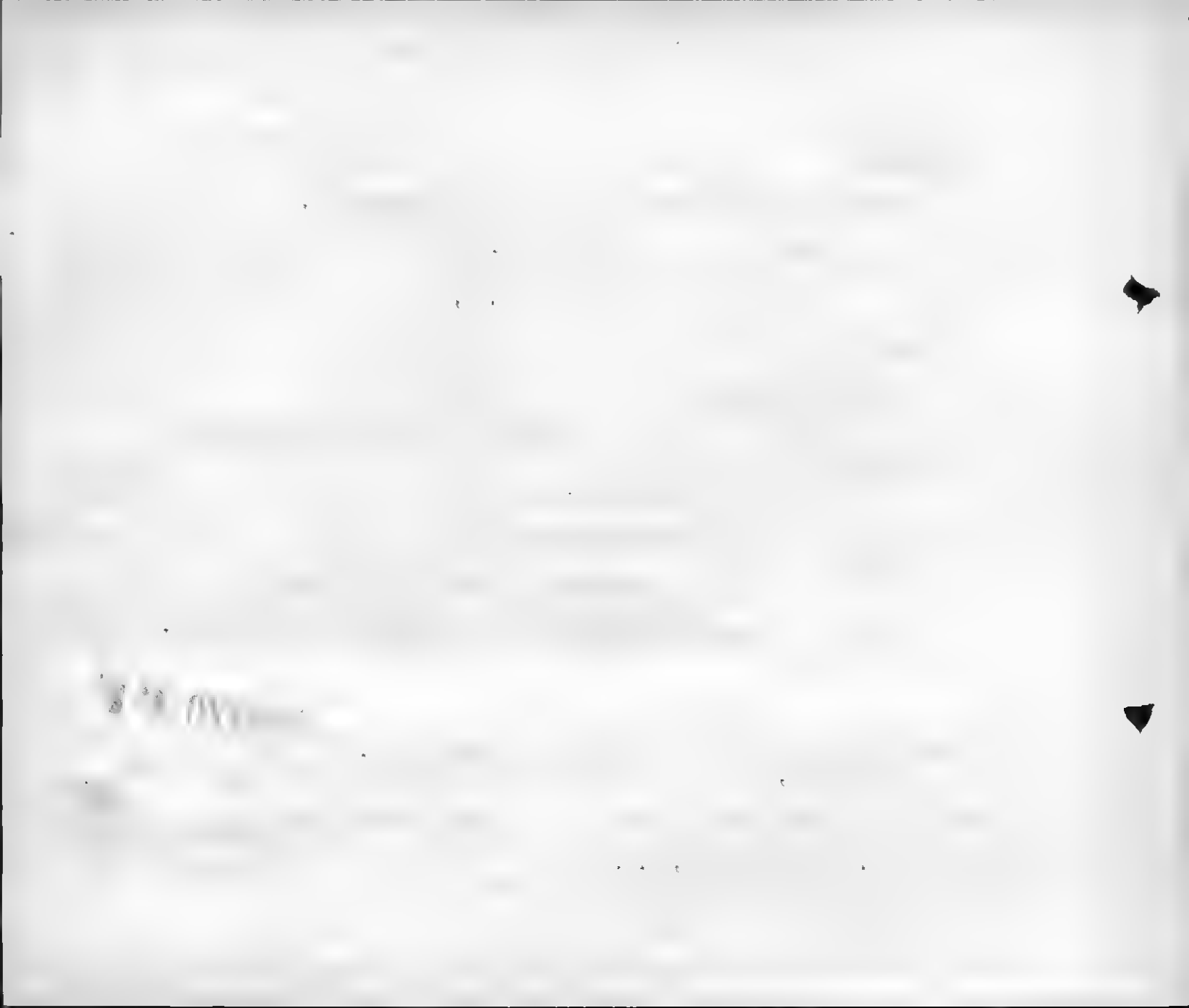
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 17 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 17 d. STREET ADDRESS 3401 Woodbrook Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle MMI Last Weinstein		4. DATE OF DEATH Month March Day 16 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 16 Hours 56 Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Kasanowitz	
14. MOTHER'S MAIDEN NAME Fannie Greenberg		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Records: SpringGroveStateHospital Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial failure DUE TO (c) Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 1 month plus years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of breast with bony and other metastases; diabetes mell.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/16/1956 , to Mar. 16, 1956 , that I last saw the deceased alive on March 16, 1956 , and that death occurred at 6:55 PM , from the causes and on the date stated above.		
ACTUAL SIGNATURE T. Glyne Williams M.D. Spring Grove State Hospital		DATE SIGNED 3/17/56
PHYSICIAN'S NAME (Type) T. Glyne Williams, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3-18-56	22c. NAME OF CEMETERY OR CREMATORY Mishken Israel Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis ADDRESS 2100 Eutaw Place	24a. REC'D BY REGISTRAR DATE 3/17/56	24b. REGISTRAR'S SIGNATURE W. E. Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Items 8, 9 Filled in 1-13-56 at

2517

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2414 Meadow Rd.</u>				STREET ADDRESS (If rural give location) <u>3807 Hudson St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>DOROTHY MAY WEITZEL</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>March 30, 1956.</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>September 14, 1908</u>	
9. AGE last birthday: <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Press Operator</u>		11. BIRTHPLACE (State or foreign country): <u>Erwin, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles A. Bolyard</u>				14. MOTHER'S MAIDEN NAME: <u>Lillie M. Bishof</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>(If Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>James J. Weitzel, 3807 Hudson St.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) <u>Malignancy - Carcinoma, breast</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yr.?</u>	
ANTECEDENT CAUSE (S):		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(B) <u>Metastasis</u>					
		DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Oct. 1954</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma, rig't breast</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 1954</u> to <u>Mar 28, 1956</u> that I last saw the deceased alive on <u>Mar. 28, 1956</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Henry Selmenow</u>		M.D.		ADDRESS <u>1308 Rutaw Place</u>		DATE SIGNED <u>4/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD., MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-2-56</u>		REGISTRAR'S SIGNATURE <u>Wm. H. Luck</u>		24. FUNERAL DIRECTOR <u>Charles S. Geiler</u>		ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1837
D. V. 1/10/37

2674

CERTIFICATE OF DEATH

Reg. Dist. No. 27

Item 2, Film G194 3-22-56 e

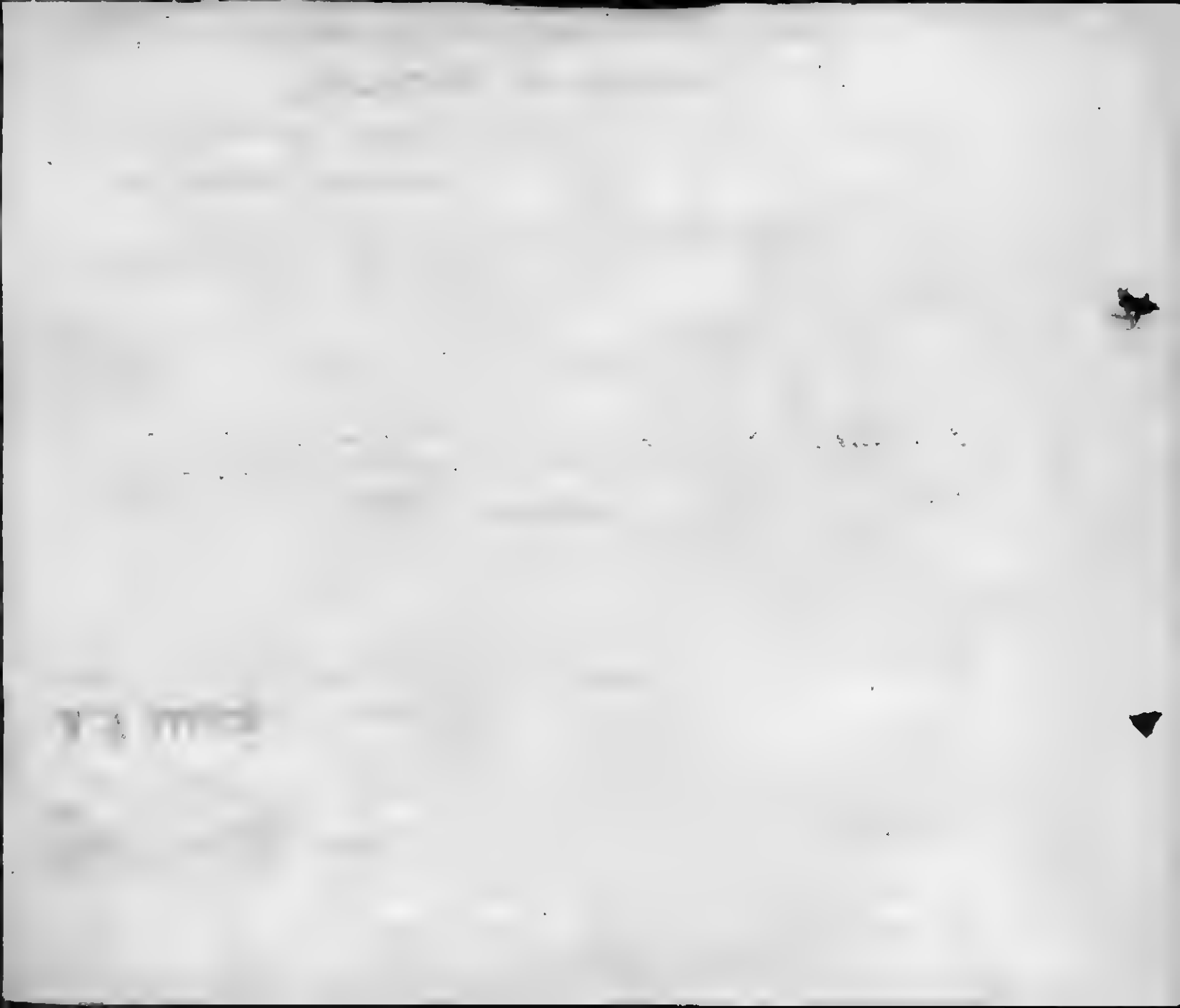
1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	STATE <u>MARYLAND</u>	CITY <u>Baltimore</u>	CITY <u>Baltimore</u>
CITY <u>Cockeysville</u>	LENGTH OF STAY <u>6 years</u>	CITY <u>Baltimore</u>	CITY <u>Baltimore</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home of Md</u>	STREET ADDRESS <u>4330 Parkside Dr.</u>		
3. NAME OF DECEASED (Type or Print) <u>Mary E. Whitaker</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 15 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept 11 1877</u>
9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR (Months) (Days)	IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>J. WILLIAM FRAZIER</u>		14. MOTHER'S MAIDEN NAME <u>JULIA L. BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>FRANK L. SMITH JR</u> <u>COCKEYSVILLE MD</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
X IMMEDIATE CAUSE (A) <u>Pneumonia</u>			
DUE TO ANTECEDENT CAUSE(S) (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 14</u> 19 <u>56</u> to <u>March 15</u> 19 <u>56</u> , that I last saw the deceased alive on <u>March 14</u> 19 <u>56</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Walter T. Lee</u>		DATE SIGNED <u>3/15/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR, <u>Mr. Frank Smith</u>	
DATE THEREOF <u>3/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Coke Farm Cemetery Baltimore Co. Md.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Inc.</u>		ADDRESS <u>1217 E. Baltimore</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



2518

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

COUNTY *Balto. 22.* MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) *Dundalk.* LENGTH OF STAY *life.*
 TOWN
 HOSPITAL OR INSTITUTION OR STREET ADDRESS *8811 Wise Ave.*

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Do.* COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN *me*
 STREET ADDRESS (If rural, give location) *#1.*

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE

(Month)

(Day)

(Year)

OF DECEASED:

*JOHN.**WIDRANSKY JR*

OF DEATH:

*MAY. 18**1956*

5. SEX:

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

*Male**White**Single**Oct. 18, 1909**46 yrs.*

Months Days Hours Min.

46

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

*no.**213-07-6323**Pete Binco. address as in #1.*

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

440X

Immediate cause

(a) DUE TO

Myocardial Failure.

INTERVAL BETWEEN ONSET AND DEATH

6 hours.

Antecedent cause(s)

(b) DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

Hypertensive Cardiovascular disease 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan. 17, 1954* to *3/18, 1956*, that I last saw the deceased alive on *3/18, 1956*, and that death occurred at *1:30 P.M.*, from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

*Louis N. Tollin M.D.**6908 North Pt Rd. Balto. 19.**3/18/56*

23. BURIAL, CREMATION, or other disposal (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

*BURIAL**3-21-56**SACRED HEART - MARY BALTO. Co. Md**md*

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*March 20-1956**William M Kelly**Walter Burke Bradley, Dundalk, Md.**Dundalk, Md.*

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SHIRAZ V. S.

151

2675

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1005 E. Belvedere e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HAL		First HAL		Middle H. WIGINGTON		Last		4. DATE OF DEATH Month March Day 8 Year 19 56	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 8, 1897		9. AGE (In years last birthday) 58 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Tire Company		11. BIRTHPLACE (State or foreign country) Morristown, Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Wigington				14. MOTHER'S MAIDEN NAME Manie Hensley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 214-12-9819		17. INFORMANT Address Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE, AORTA DUE TO ARTERIOSCLEROSIS, AORTA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 12 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Proteus vulgaris septicemia								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m., p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 2, 1956 , to March 8, 1956 . That death occurred at 5:45 A.M. and that death occurred at 5:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 3-8-56									
ACTUAL SIGNATURE Irving Freeman				M.D. VAH, FORT HOWARD, MARYLAND					
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland			22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John Cook-Blight, Inc				ADDRESS 6009 Harford Rd. Balto. 11, Md.		24a. REC'D BY REGISTRAR DATE 1-13-56		24b. REGISTRAR'S SIGNATURE Dan L. Larkins	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD V. S.

MAR 1 1900

RECEIVED

02664

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2676

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgemere</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgemere</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2538 Lycomore Ave</u>		STREET ADDRESS (If rural, give location) <u>2538 Lycomore Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Debra</u> (Middle) <u>M</u> (Last) <u>Williams</u>	4. DATE OF DEATH	(Month) <u>3</u> (Day) <u>6</u> (Year) <u>1956</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb. 5-1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Edgemere Md</u>
13. FATHER'S NAME <u>Epiphany Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Dolores Harbrough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT AND ADDRESS <u>Dolores Williams 2538 Lycomore Ave</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) None(c) None

INTERVAL BETWEEN ONSET AND DEATH

2 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg, etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 4th 1956, to March 6th 1956, that I last saw the deceased alive on 6th March 1956 and that death occurred at 5 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3-7-56</u>	<u>Mt. Calvary Cem</u>	<u>A. A. Co.</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/7/56</u>	<u>[Signature]</u>	<u>Samuel W. Sullivan Jr.</u>	<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2677

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 22 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 126 Rosewood Ave.		e. STREET ADDRESS 5311 Old Frederick Rd.	
3. NAME OF DECEASED (Type or print) First MAmie Middle M Last WILMOTH		4. DATE OF DEATH Month March Day I Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24 1873
9. AGE (n years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Basil Iglehart		14. MOTHER'S MAIDEN NAME Amanda Burns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) II II II		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Loree I Wilmoth		Address 5311 Old Frederick Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1936 to March 1, 1956 , that I last saw the deceased alive on Feb. 4, 1956 , and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1635 N. Calvert St. DATE SIGNED 3/1/56 ACTUAL SIGNATURE John H. Trescher M.D. PHYSICIAN'S NAME (Type) John H. Trescher			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 3	
22c. NAME OF CEMETERY OR CREMATORY Upper Seneca Baptist		22d. LOCATION (City, town, or county) (State) Cedar Grove Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W Barber Francis H Barber		24a. REC'D BY REGISTRAR 3/5/56	
ADDRESS Laytonsville, Md.		24b. REGISTRAR'S SIGNATURE T.E. Harry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, attending physician, or funeral director. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 & 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02666

Reg. Dist. No.

2678

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 319 E <u>De Ry</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rheem MFG Co.</u>				d. STREET ADDRESS <u>Dundalk</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE Henry Woolery</u>				4. DATE OF DEATH Month Day Year <u>3 16 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-99</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rheem MFG Co</u>		11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Don't know</u>				14. MOTHER'S MAIDEN NAME <u>Don't know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1916-1924</u>		17. INFORMANT <u>Rheem MFG Co Edgemere Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic H.D</u> (c) <u>stating the underlying cause last.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 min</u> <u>'64</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>'64</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-17-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 20, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>				24a. REC'D BY REGISTRAR <u>March 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Edith Hurley</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, and the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S. DEPT. OF AGRICULTURE

OFFICE OF THE SECRETARY
WASHINGTON, D. C.

2679

CERTIFICATE OF DEATH

02667

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville.</u>				c. LENGTH OF STAY IN lb <u>10 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Broadway Rd.</u>				d. STREET ADDRESS <u>Broadway Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Albert</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27, 1873</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>2</u> Min.	IF UNDER 24 HRS. Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher, Youngstown Ohio, Ohio</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>Wright</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Finley Smith, Broadway Rd, Balto. Co.</u>				Address <u>Nr. Lutherville.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Renal-Vascular disease with hypertension</u> 4422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs +</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>th</u> , to <u>March 19, 1956</u> , that I last saw the deceased alive on <u>March 12, 1956</u> , and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>606 Baltimore Ave Towson Md</u> DATE SIGNED <u>3/19/56</u>							
ACTUAL SIGNATURE <u>Harry H. Wright</u> M.D.				PHYSICIAN'S NAME (Type) <u>Harry H. Wright</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Mar. 2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lake Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Youngstown, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wright</u>				ADDRESS <u>4101 EDMONDSON AVE</u>		24a. REC'D BY REGISTRAR <u>March 20, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Anne Mae Ray</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A 0000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02668

2680

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Catonsville	6yrs 5mths 4dys	TOWN Baltimore City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRING GROVE STATE HOSP.		STREET ADDRESS (If rural give location) 1711 E. Lombard St. -Balto. 31	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
KATHERINE ZACHOW		March 4, 19 56	
5 SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: July 7, 1874
9. AGE last birthday 81 yrs		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): embroidering		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Ludwig Karl Zackow		14. MOTHER'S MAIDEN NAME: Pauline Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) IMMEDIATE CAUSE Cerebral Hemorrhage (Right)			
(B) ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 30, 19 49 , to March 4, 19 56 , that I last saw the deceased alive on March 4, 19 56 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
SIGNATURE J.P. Brown		M. D. James J. Goss Hospital DATE SIGNED 3/4/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/7/56	Mt Carmel	Balto Md
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
March 6, 1956	A. W. Hedrick	Paul & Seymour Hayford & Co	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02669

2681

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY IN 1b 36 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Reisterstown Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle Elizabeth Last Zepp				4. DATE OF DEATH Month March Day 20 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1873		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Larkins				14. MOTHER'S MAIDEN NAME Sarah A. Frank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Joseph F. Zepp, Owings Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C-V Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH 3 days 16 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 11-9-39 , 19____, to 3-20-56 , 19____, that I last saw the deceased alive on 3-19-56 , 19____, and that death occurred at 12:30 A. , from the causes and on the date stated above ADDRESS (Street, city or town, state) 6 Hanover Road DATE SIGNED 3-20-56							
ACTUAL SIGNATURE D. D. Caples				M.D. 6 Hanover Road			
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Grace Methodist		22d. LOCATION (City, town, or county) (State) Baltimore County	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 3-20-56		24b. REGISTRAR'S SIGNATURE Mary S. Eline	

3 A 600

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2632

CERTIFICATE OF DEATH

02670

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>107 Church Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Zimmer</u> Last <u>Zimmer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1880</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip V. Zimmer</u>		14. MOTHER'S MAIDEN NAME <u>Emma Pick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. George Zimmer</u>		Address <u>Pikesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Sclerosis</u> DUE TO <u>Diabetes mellitus</u> (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mons</u> <u>5 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 1</u> , 19 <u>55</u> , to <u>MAR 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MARCH 2</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller</u> M.D.		ADDRESS (Street, city or town, state) <u>Pikesville, Md</u> DATE SIGNED <u>3/3/56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. James A. Miller</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>MARCH 5, 1956</u>	<u>Wm. H. K. Cemetery</u>	<u>Pikesville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>		ADDRESS <u>Pikesville</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	
DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02671

2683

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 12, Film G194 4-2-56 et

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville,		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in The Pines 16 Fusting Ave.		STREET ADDRESS (If rural, give location) 6006 Glen Oak Ave.	
3. NAME OF DECEASED (Type or Print) (First) Felicia (Middle) Messina (Last) Zito		4. DATE OF DEATH (Month) (Day) (Year) March 24, 1956	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow	8. DATE OF BIRTH May 31, 1868
9. AGE last birthday 87 yrs.		10. AGE last birthday If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Salatore Messina		14. MOTHER'S MAIDEN NAME Dominica	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mr. Joseph P. Zito 4110 Milford Mill Road			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4-20-0 Immediate cause (a) uremia - arteriosclerotic heart disease Antecedent cause(s) (b) Generalized arteriosclerosis Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 14 days
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2.13.56 to 3.24.56 that I last saw the deceased alive on 3.21.56 , 19 56 , and that death occurred at 7.45 P.m. , from the causes and on the date stated above. SIGNATURE Harry S. Gumbel M.D. ADDRESS 4605 Edmondson Ave. DATE SIGNED March 26, 1956			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF March 28, 1956 NAME OF CEMETERY OR CREMATORY New Cathedral LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REG. 3/27/56		REGISTRAR'S SIGNATURE John O. Mitchell & Sons Inc. ADDRESS 1900 Rutaw Pl.	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



02672

MARYLAND

STATE DEPARTMENT OF HEALTH

2684

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural, give location) <u>313 South Collington Avenue</u>	
3. NAME OF DECEASED (First) <u>ALBERT</u> (Middle) (Last) <u>ZLOTKOWSKI</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>8</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 30, 1889</u> <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Extract Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Poland Poland</u>
13. FATHER'S NAME <u>Alexander A Zlotkowski</u>		14. MOTHER'S MAIDEN NAME <u>Lydia MN: Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY No. <u>212-10-0965</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
163X Immediate cause (a) <u>CARCINOMA OF LUNG</u>			INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>1/24/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Biopsy, lymph node, left axilla</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> attended the deceased from <u>Jan. 7, 1956</u> , to <u>March 8, 1956</u> , and that death occurred at <u>12:40 p.m.</u> on <u>March 8, 1956</u> , from the causes and on the date stated above.			
SIGNATURE <u>Francis G. Dickey</u>		ADDRESS <u>M.D. Chief Medical Service, VAH, FORT HOWARD, MARYLAND</u>	
DATE <u>March 13/56</u>		DATE SIGNED <u>3-8-56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>RB 12-56</u>		LOCATION (City, town, or county) (State) <u>Baltimore 22, Maryland</u>	
24. FUNERAL DIRECTOR <u>Fred W. Ozazewski</u>		ADDRESS <u>1930 Eastern Ave., Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING

